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SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

JASON KANDER

SECRETARY OF STATE

MISSOURI REGISTER

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Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at http://www.sos.mo.gov/adrules/pubsched.asp

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HOW TO CITE RULES AND RSMo

RULES—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 28, *Missouri Register*, page 27. The approved short form of citation is 28 MoReg 27.

The rules are codified in the *Code of State Regulations* in this system—

Title	***Code of State Regulations***	**Division**	**Chapter**	**Rule**
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—The most recent version of the statute containing the section number and the date.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER TERMINATING EMERGENCY RESCISSION

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director hereby terminates an emergency rescission effective May 29, 2013, as follows:

22 CSR 10-2.020 General Membership Provisions **is terminated**.

A notice of emergency rulemaking containing the emergency rescission was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1705).

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER TERMINATING EMERGENCY RULE

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director hereby terminates an emergency rule effective May 29, 2013, as follows:

22 CSR 10-2.020 General Membership Provisions **is terminated**.

A notice of emergency rulemaking containing the text of the emergency rule was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1705–1715).

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER TERMINATING EMERGENCY AMENDMENT

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, and section 103.080.3, RSMo Supp. 2012, the director hereby terminates an emergency amendment effective May 29, 2013, as follows:

22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges **is terminated**.

A notice of emergency rulemaking containing the text of the emergency amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1717–1719).

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER TERMINATING EMERGENCY AMENDMENT

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director hereby terminates an emergency amendment effective May 29, 2013, as follows:

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges **is terminated**.

A notice of emergency rulemaking containing the text of the emergency amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1719–1724).

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER TERMINATING EMERGENCY AMENDMENT

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, and section 103.089, RSMo Supp. 2012, the director hereby terminates an emergency amendment effective May 29, 2013, as follows:

22 CSR 10-2.070 Coordination of Benefits **is terminated**.

A notice of emergency rulemaking containing the text of the emergency amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1726).

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER TERMINATING EMERGENCY AMENDMENT

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director hereby terminates an emergency amendment effective May 29, 2013, as follows:

22 CSR 10-2.090 Pharmacy Benefit Summary **is terminated**.

A notice of emergency rulemaking containing the text of the emergency amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1729–1732).

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER TERMINATING EMERGENCY RESCISSION

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director hereby terminates an emergency rescission effective May 29, 2013, as follows:

22 CSR 10-3.020 General Membership Provisions **is terminated**.

A notice of emergency rulemaking containing the emergency rescission was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1736).

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER TERMINATING EMERGENCY RULE

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director hereby terminates an emergency rule effective May 29, 2013, as follows:

22 CSR 10-3.020 General Membership Provisions **is terminated**.

A notice of emergency rulemaking containing the text of the emergency rule was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1736–1743).

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER TERMINATING EMERGENCY AMENDMENT

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director hereby terminates an emergency amendment effective May 29, 2013, as follows:

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges **is terminated**.

A notice of emergency rulemaking containing the text of the emergency amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1748–1754).

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER TERMINATING EMERGENCY AMENDMENT

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, and section 103.089, RSMo Supp. 2012, the director hereby terminates an emergency amendment effective May 29, 2013, as follows:

22 CSR 10-3.070 Coordination of Benefits **is terminated**.

A notice of emergency rulemaking containing the text of the emergency amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1755).

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER TERMINATING EMERGENCY AMENDMENT

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director hereby terminates an emergency amendment effective May 29, 2013, as follows:

22 CSR 10-3.090 Pharmacy Benefit Summary **is terminated**.

A notice of emergency rulemaking containing the text of the emergency amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1758–1761).

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo Supp. 2012.

EXECUTIVE ORDER
13-05

WHEREAS, the State of Missouri is being impacted by a severe winter storm, starting on February 20, 2013 and continuing, that is causing or is forecast to cause heavy snow, sleet, freezing rain and ice across the state; and

WHEREAS, hazardous travel conditions and utility interruptions are expected during the pendency of this storm; and

WHEREAS, this winter weather event has the potential to create a condition of distress and hazard to the safety, welfare, and property of the citizens of the State of Missouri beyond the capabilities of some local jurisdictions, and other established agencies; and

WHEREAS, the State will continue to be proactive where the health and safety of the citizens of Missouri are concerned; and

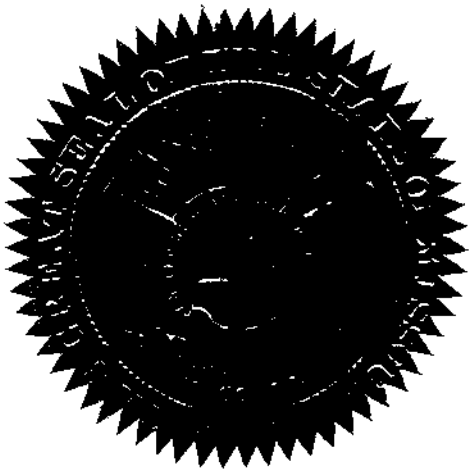
WHEREAS, the resources of the State of Missouri may be needed to assist affected jurisdictions and to help relieve the condition of distress and hazard to the safety and welfare of our fellow Missourians; and

WHEREAS, an invocation of the provisions of Sections 44.100 and 44.110, RSMo, will be required to ensure the protection of the safety and welfare of the citizens of Missouri.

NOW, THEREFORE, I, JEREMIAH W. (JAY) NIXON, GOVERNOR OF THE STATE OF MISSOURI, by virtue of the authority vested in me by the Constitution and Laws of the State of Missouri, including Sections 44.100 and 44.110, RSMo, do hereby declare that a State of Emergency exists in the State of Missouri. I do hereby direct that the Missouri State Emergency Operations Plan be activated.

I further authorize the use of state agencies to provide assistance, as needed.

This order shall terminate on March 21, 2013, unless extended in whole or in part.



IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 21st day of February, 2013.

Jeremiah W. (Jay) Nixon
Governor

ATTEST:

Jason Kander
Secretary of State

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register.* If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety- (90-) day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
Boldface text indicates new matter.
[Bracketed text indicates matter being deleted.]

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 400—Office of Educator Quality

PROPOSED RULE

5 CSR 20-400.125 Actions of the State Board of Education Relating to Applications for Educator Certificates

PURPOSE: The State Board of Education is authorized to grant educator certification in any of the public schools of the state and to establish requirements and qualifications for those certificates. This rule establishes procedures for review of applications of individuals convicted of a felony or crime involving moral turpitude, whether or not sentence is imposed; applicants whose license has been revoked in Missouri or in another jurisdiction; and applicants seeking to appeal a denial of license by the Office of Educator Quality.

(1) Any application for an educator certificate for an individual who has been convicted of a felony or crime involving moral turpitude, whether or not sentence is imposed, including candidates for a Missouri educator certificate who are currently enrolled in professional education courses in conjunction with state-approved teacher preparation programs, shall be reviewed by the Office of Educator Quality within the Department of Elementary and Secondary Education (department) and recommendations made to the State Board of Education (board). However, certificates may only be issued upon motion of the board adopted by a unanimous affirmative vote of those members present and voting.

(A) Conviction for purposes of this rule does not include offenses, other than those listed in section 168.071.6, RSMo, for which the applicant has successfully completed a suspended imposition of sentence.

(B) Applicants with a criminal conviction shall provide the following:

1. Information relating to being found guilty, a plea of guilty, receipt of a suspended imposition of sentence, receipt of a suspended execution of sentence, or entering a plea of *nolo contendere* for any violation of any laws of a state, the United States, or any other country, other than a traffic violation; including information on the date of the court action, the applicant's age at the time of the underlying offense, the facts of the crime, and whether the conduct that was the basis for the conviction was in the scope of the applicant's duties while employed by a public or private school or school district;

2. A statement by affidavit or under oath as to rehabilitative steps completed by the applicant relating to applicant's criminal conduct; and

3. A completed background check processed by the Missouri State Highway Patrol (Highway Patrol) and/or the Federal Bureau of Investigation (FBI).

(C) The application shall be placed on the agenda of the board as soon as reasonably possible. The applicant will be notified of the date, time, and place of the board meeting. Consideration by the board will consist of a record review of the application and additional documents. The applicant will not have the opportunity to present additional evidence or testify. The applicant will be notified in writing of the decision of the board.

(2) Any application for an educator certificate submitted by an individual who has been subject to previous disciplinary action by the board or by a licensing authority in another state or political jurisdiction shall only be granted by affirmative vote of the board.

(A) Applicants for a Missouri educator certificate who have had an educator certificate revoked by another certifying authority will not be eligible to be considered for Missouri certification until such time as they have the revocation cleared by the certificating authority and the applicant holds a valid certificate from that authority.

(B) Recommendation to the board by the commissioner of education for certification under this section shall be based only on a completed application which shall include:

1. Information regarding teaching certificates or similar titles and/or other professional licenses or similar titles held, including but not limited to disciplinary actions, denials, restrictions, revocations, voluntary surrenders, suspensions, reprimands, and/or investigations;

2. A consent authorizing the department as it deems necessary or appropriate to make contact with, interview, consult, obtain documentation and verification from other persons and sources within or without Missouri with respect to the applicant and the applicant's request for certification;

3. Transcripts and other evidence necessary to show compliance with all the requirements for certification that are in effect at the time application for recertification is made; and

4. Other information including recent employment and references requested by the board that may be deemed relevant to the request for recertification.

(C) The application shall be placed on the agenda of the board as soon as reasonably possible. The applicant will be notified of the date, time, and place of the board meeting. Consideration by the board will consist of a record review of the application and related documents. The applicant will not have the opportunity to present additional evidence or testify. The applicant will be notified in writing of the decision of the board.

(3) Issuance of certificates not otherwise addressed under sections (1) and (2) of this rule shall be made by the Office of Educator Quality based upon the standards adopted by the board. Applicants that are denied will be advised in writing of the reason(s) why certification is denied and at the same time will receive notice of the process for appeal.

(A) The applicant, within thirty (30) days of receipt of written notice of denial, may request the commissioner of education to review the decision of the Office of Educator Quality. The applicant shall provide all documentation to be considered by the commissioner of education or a designee in reviewing the application.

(B) The commissioner of education will notify the applicant in writing of the decision.

(C) If the commissioner of education approves the decision of the Office of Educator Quality in denying certification, the applicant, within thirty (30) days from the date the commissioner sends written notice of the decision, may file a written notice of appeal with the board by addressing the notice to the secretary of the State Board of Education, PO Box 480, Jefferson City, MO 65102-0480. In addition to stating the applicant's desire to appeal the denial of certification, the notice shall include a statement of each reason the applicant relies upon to demonstrate support for the reversal of denial.

(D) The applicant's appeal shall be placed on the agenda of the board as soon as reasonably possible. The applicant will be notified of the date, time, and place of the board meeting.

(E) The appeal will consist of a record review of the application, related materials reviewed by the commissioner of education, and the applicant's additional statements. The applicant will not have the opportunity to present additional evidence or testify. The applicant will be notified in writing of the decision of the board.

AUTHORITY: sections 161.092 and 168.021, RSMo Supp. 2012, and section 168.011, RSMo 2000. Original rule filed Feb. 27, 2013.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in the support of or in opposition to this proposed rule with the Department of Elementary and Secondary Education, Attention: Paul Katnik, Interim Assistant Commissioner, Office of Educator Quality, PO Box 480, Jefferson City, MO 65102-0480 or by email at educatorquality@dese.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 600—Office of Early and Extended Learning

PROPOSED AMENDMENT

5 CSR 20-600.110 General Provisions Governing Programs Authorized Under the Early Childhood Development Act. The State Board of Education is proposing to amend the purpose, sections (1) and (2), and the incorporated by reference material.

PURPOSE: This amendment clarifies the title and language of the incorporated by reference material to reflect the new curriculum being used.

PURPOSE: The Department of Elementary and Secondary Education is authorized by the Early Childhood Development Act to administer a program of grants to local public school districts for the provision of early childhood screening, parent education, and programs for developmentally delayed children. This rule sets forth the general provisions governing those programs. This rule incorporates by reference the ***Early Childhood Development Act*** *[Program Guidelines and]* ***Administrative Manual****.*

(1) All programs and projects carried out by school districts under the Early Childhood Development Act (ECDA) shall be conducted in conformity with—

(B) The state *Early Childhood Development Act [Program Guidelines and] Administrative Manual*, revised *[April 2010]* **February 2013**, which is incorporated by reference and made a part of this rule as published by the Department of Elementary and Secondary Education (*[DESE]* **department**) and is available at the Early *[Childhood Education]* **Learning** Section, 205 Jefferson Street, PO Box 480, Jefferson City, MO 65102-0480 or on *[DESE's]* **the department's** website. This rule does not incorporate any subsequent amendments or additions. The *Early Childhood Development Act [Program Guidelines and] Administrative Manual* interprets state statutory requirements for the programs and establishes program management procedures consistent with state law and practice.

(2) Any rule or interpretation of a rule promulgated by the State Board of Education in exercising its responsibilities under the statute may be waived by the assistant commissioner, *[Division of School Improvement]* **Office of Early and Extended Learning**, upon his/her determination that a situation exists in which the application of the rule or interpretation would work an extreme hardship upon the affected party, or would work to the detriment of the intended beneficiaries of the program.

AUTHORITY: sections 178.691–178.699, RSMo 2000 ***and Supp. 2012,*** *and section 161.092, RSMo Supp. [2009]* ***2012****. This rule previously filed as 5 CSR 50-270.010. Original rule filed April 4, 1985, effective Sept. 3, 1985. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed Feb. 27, 2013.*

PUBLIC COST: This proposed amendment is estimated to cost $15,000,000 for Fiscal Year 2013, with the cost recurring annually for the life of the rule based upon yearly appropriations from the General Assembly.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Elementary and Secondary Education, Attention: Early Learning Section, PO Box 480, Jefferson City, MO 65102-0480 or by email at eel@dese.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. **Department Title:** Title 5 Department of Elementary and Secondary Education
Division Title: Division 20 Division of Learning Services
Chapter Title: Chapter 600 Office of Early and Extended Learning

Rule Number and Name:	5 CSR 20-600.110 General Provisions Governing Programs Authorized Under Early Childhood Development Act
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivisions	Estimated Cost of Compliance in the Aggregate
Department of Elementary and Secondary Education	Fifteen million dollars ($15,000,000) was appropriated for this program in Fiscal Year 2013

III. WORKSHEET

The proposed amendment is estimated to cost fifteen million dollars ($15,000,000) for Fiscal Year 2013 with the cost recurring annually for the life of the rule based upon yearly appropriations from the General Assembly.

IV. ASSUMPTIONS

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 35—Children's Division
Chapter 100—Tax Credits

PROPOSED AMENDMENT

13 CSR 35-100.010 Residential Treatment Agency Tax Credit. The division is amending the purpose and sections (1)–(5), (7), and (11), and adding the Tax Credit Transfer Form to the rule.

PURPOSE: This rule is being amended to reflect changes that were made in section 135.1150, RSMo, as a result of SB 86 (2007), Special Session HB 1 (2007), and HB 1172 (2012). Additionally typographical changes have been made.

PURPOSE: This rule describes the procedures for the implementation of section 135.1150, RSMo [Supp. 2006], Residential Treatment Agency Tax Credit Act[, to reflect the requirements of SB 614 (2006)].

(1) In general, a qualified residential treatment agency may apply for tax credits on behalf of taxpayers who make cash donations to the agency. The amount of total credits available to any qualified residential treatment agency cannot exceed *[forty percent (40%) of]* the total funds received from the Department of Social Services in the preceding twelve (12) months. Those who donate to qualifying providers are eligible to receive a tax credit up to fifty percent (50%) of their donation. Qualified residential treatment agencies that accept these donations are required to remit payments equivalent to the amount of the tax credit to the state of Missouri.

(2) Definition of terms*[:]*—

(A) "Certificate," a tax credit certificate issued to a taxpayer who makes an eligible *[monetary]* donation to a qualified residential treatment agency as described under section 135.1150, RSMo;

(B) "Eligible *[monetary]* donation," *[a cash]* donation**s** received from a taxpayer by a qualified residential treatment agency that *[is]* **are** used solely to provide direct care services to children who are residents of this state. Direct care services include but are not limited to increasing the quality of care and service for children through improved employee compensation and training**. Eligible donations may include cash, publicly traded stocks and bonds, and real estate**;

(C) "Qualified residential treatment agency," a residential treatment care facility that—

1. Is licensed under section 210.484, RSMo; and

2. Is accredited by—

A. Council on Accreditation (COA); or

B. Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or

C. Commission on Accreditation of Rehabilitation Facilities (CARF); and

3. Is under contract with the Department of Social Services to provide treatment services for children who are residents or wards of residents of this state; and

4. Receives *[monetary]* donations. Any agency that operates more than one (1) facility or at more than one (1) location can only be eligible for the tax credit for eligible *[monetary]* donations made to facilities or locations of the agency which are licensed and accredited;

(D) "Taxpayer," any of the following individuals or entities who make eligible *[monetary]* donations to a qualified residential treatment agency*[:]*—

1. A person, firm, partner in a firm, corporation, or a shareholder in an S corporation doing business in the state of Missouri, and subject to the state income tax imposed in Chapter 143, RSMo;

2. A corporation subject to the annual corporation franchise tax imposed in Chapter 147, RSMo;

3. An insurance company paying an annual tax on its gross premium receipts in this state**;**

4. *[or a]***A**ny other financial institution paying taxes to the state of Missouri or any political subdivision of the state under Chapter 148, RSMo; **or**

5. Any charitable organization which is exempt from federal income tax and whose Missouri unrelated business taxable income, if any, would be subject to the state income tax imposed under Chapter 143, RSMo; and

(3) Beginning January 1, 2007, any taxpayer will be allowed to claim a credit against their state tax liability, as defined in subsection (2)(E) of this rule, equivalent to fifty percent (50%) of the eligible *[monetary]* donation the taxpayer made to a qualified residential treatment agency. The amount of the tax credit claimed may not exceed the amount of the taxpayer's state income tax liability in the tax year that the credit is being claimed.

(4) Qualified residential treatment agencies must apply for the tax credit on behalf of the taxpayers. Required information includes:

(A) A complete and accurate **Residential Treatment Agency Tax Credit** *[a]***A**pplication (Attachment A, included herein). Applications may be obtained by writing to*[:]*—

Department of Social Services
Attention: Residential Treatment Agency Tax Credit
PO Box 853
Jefferson City, MO 65102-0853

(C) A statement attesting to the receipt of an eligible *[monetary]* donation, which includes the following information:

1. Taxpayer type and supporting documentation, when applicable;

*[1.]***2.** Taxpayer's name;

*[2.]***3.** Taxpayer's identification number;

*[3.]***4.** Amount of the eligible *[monetary]* donation **and supporting documentation, when applicable**;

*[4.]***5.** Amount of anticipated tax credit;

*[5.]***6.** Date the donation was received by the agency; **and**

*[6.]***7.** Signature of the executive director;

(D) Payment from the qualified residential treatment agency equal to the value of the tax credit for which the application is being submitted. Checks must be made payable to the Department of Social Services*[.]***; and**

(E) Verifying documentation must be attached to the tax credit application. The type of documentation required will depend on the type of donation. Required documentation includes the following:

1. Cash—legible receipt from the residential treatment agency which indicates the name and address of the organization; name, address, and telephone number of the contributor; amount and date the contribution was received; and signature of a representative of the residential treatment agency receiving the contribution;

2. Check—photocopy of the canceled check, front and back—if not possible then copy of the original check and a receipt from the residential treatment agency including the same information required of a cash donation as described in paragraph (4)(E)1. of this rule;

3. Credit card—legible transaction receipt with the name and address of the residential treatment agency; contributor's name, address, and telephone number; amount and date the contribution was received; and signature of a representative of the residential treatment agency receiving the contribution. Receipts should have the credit card account number blacked out;

4. Money order or cashier's check—legible copy of the original document with the name and address of the residential treatment agency; contributor's name, address, and telephone number; amount and date the contribution was received; and signature of a representative of the residential treatment agency receiving the

contribution;

5. Values of contributed stocks and bonds must be determined by a reputable source (e.g., *Wall Street Journal*, New York Stock Exchange (NYSE), National Association of Securities Dealers Automated Quotations (NASDAQ), etc.). Information required when submitting applications for tax credit shall include the source and date the stock was valued and how the bond amount was determined;

6. The value of contributions of real estate shall be equal to the lowest of at least two (2) qualified independent appraisals for commercial, vacant, or residential property that has been determined to have a value of over twenty-five thousand dollars ($25,000). Commercial, vacant, or residential property having a value of twenty-five thousand dollars ($25,000) or less will require only one (1) appraisal; and

7. Contributions that include a benefit to the donor—documentation required will depend on how the type of contribution was made (i.e., cash, check, etc.). The same information is required as described in paragraphs (4)(E)1.–4. of this rule. Additional information required includes the type of function or event from which the benefit was received, description of the benefit received (if an auction item, identify the item received), gross amount of the contribution, fair market value of the benefit, and how the fair market value of the benefit was determined.

(5) All applications and payments must be submitted within twelve (12) months from date the eligible *[monetary]* donation was received from the taxpayer. Tax credit applications submitted more than one (1) year following the date of the contribution will be void and the right to the tax credit will be forfeited.

(7) Total tax credits issued for any qualified residential treatment agency cannot exceed *[forty percent (40%) of]* the total payments made by the Department of Social Services to the qualified residential treatment agency in the twelve (12) months preceding the month the application for the tax credit was received. In the event the total credits exceed *[forty percent (40%) of]* the total payments made to a qualified residential treatment agency by the Department of Social Services, the application and payment will be returned to the qualified residential treatment agency and may be resubmitted by the agency within thirty (30) days of the date the application was returned or within twelve (12) months from the date the *[monetary]* donation was received by the agency, whichever is later.

(11) The owner of a **residential treatment agency tax credit** certificate *[indicating a residential treatment agency tax credit]* may assign, transfer, sell, or otherwise convey the certificate. The new owner will have the same rights as the original owner. When a certificate is assigned, transferred, sold, or otherwise conveyed**,** a notarized endorsement must be submitted to the Department of Social Services within thirty (30) days of the date of the transaction. Information submitted must include:

[(A) New owner name;

(B) New owner address;

(C) New owner taxpayer identification number;

(D) Value of the tax credit (amount of claimable tax credit remaining);

(E) Date of transaction.]

(A) A complete and accurate Tax Credit Transfer Form (Attachment B, included herein). Forms may also be obtained by writing to the address provided in subsection (4)(A) and section (6) of this rule.

MISSOURI DEPARTMENT OF SOCIAL SERVICES

RESIDENTIAL TREATMENT AGENCY TAX CREDIT APPLICATION

ORGANIZATION NAME (RECEIVING THE DONATION)	CONTACT PERSON AND E-MAIL ADDRESS
ADDRESS	
TELEPHONE NUMBER	LICENSE NUMBER

DONOR INFORMATION (ATTACH ADDITIONAL PAGES IF NEEDED)

TAXPAYER TYPE (*REQUIRES SUPPORTING DOCUMENTATION - SEE INSTRUCTIONS)

☐ INDIVIDUAL ☐ CORPORATION ☐ PARTNERSHIP* ☐ S CORPORATION* ☐ LLC* ☐ CHARITABLE ORGANIZATION* ☐ FINANCIAL INSTITUTION ☐ INSURANCE COMPANY

TAXPAYER/BUSINESS NAME(S) (IF FILING MISSOURI JOINT INCOME TAX RETURN, BOTH SPOUSES' NAMES MUST BE LISTED)	TAXPAYER TELEPHONE NUMBER
TAXPAYER ADDRESS (ADDRESS, CITY, STATE, ZIP CODE)	TAXPAYER IDENTIFICATION NUMBER(S) (SOCIAL SECURITY NUMBER(S))

TYPE OF DONATION (ATTACH REQUIRED DOCUMENTATION)

*REQUIRES SUPPORTING DOCUMENTATION - SEE INSTRUCTIONS

☐ Cash* ☐ Check/Money Order* ☐ Credit Card* ☐ Publicly Traded Stocks/Bonds* ☐ Real Estate*

AMOUNT OF DONATION	AMOUNT OF TAX CREDIT (50% OF THE DONATION)	DATE OF DONATION
CONTRIBUTIONS THAT INCLUDE A BENEFIT	BENEFIT DESCRIPTION	FAIR MARKET VALUE OF THE BENEFIT

TAXPAYER TYPE (*REQUIRES SUPPORTING DOCUMENTATION - SEE INSTRUCTIONS)

☐ INDIVIDUAL ☐ CORPORATION ☐ PARTNERSHIP* ☐ S CORPORATION* ☐ LLC* ☐ CHARITABLE ORGANIZATION* ☐ FINANCIAL INSTITUTION ☐ INSURANCE COMPANY

TAXPAYER/BUSINESS NAME(S) (IF FILING MISSOURI JOINT INCOME TAX RETURN, BOTH SPOUSES' NAMES MUST BE LISTED)	TAXPAYER TELEPHONE NUMBER
TAXPAYER ADDRESS (ADDRESS, CITY, STATE, ZIP CODE)	TAXPAYER IDENTIFICATION NUMBER(S) (SOCIAL SECURITY NUMBER(S))

TYPE OF DONATION (ATTACH REQUIRED DOCUMENTATION)

*REQUIRES SUPPORTING DOCUMENTATION - SEE INSTRUCTIONS

☐ Cash* ☐ Check/Money Order* ☐ Credit Card* ☐ Publicly Traded Stocks/Bonds* ☐ Real Estate*

AMOUNT OF DONATION	AMOUNT OF TAX CREDIT (50% OF THE DONATION)	DATE OF DONATION
CONTRIBUTIONS THAT INCLUDE A BENEFIT	BENEFIT DESCRIPTION	FAIR MARKET VALUE OF THE BENEFIT

DONOR TOTALS (ALL PAGES)

TOTAL NUMBER OF CERTIFICATES REQUESTED	TOTAL AMOUNT OF CREDITS REQUESTED (ENCLOSE REMITTANCE IN THE SAME AMOUNT)

In accordance with section 135.1150 RSMo, I certify that the information provided above is true and accurate. On the dates indicated, _____ (ORGANIZATION NAME) accepted the indicated eligible donation(s) from the above named taxpayer(s).

Donations will be used solely to provide direct care services to children who are residents of this state. Direct care services include but are not limited to increasing the quality of care and service for children through improved employee compensation and training. I also understand the amount of the certificate will be reduced if it is determined the taxpayer has an outstanding balance owed to the Missouri Department of Revenue (Section 135.815 RSMo).

EXECUTIVE DIRECTOR SIGNATURE	
PRINTED NAME	DATE

Certificates will be mailed directly to the taxpayer.

All incomplete or inaccurate applications and payments will be returned to the Residential Treatment Agency.

FOR OFFICIAL USE ONLY

DSS APPROVAL	DATE PROCESSED

MO 886-4263 (12-12) DBF-10

TAXPAYER TYPE (*REQUIRES SUPPORTING DOCUMENTATION - SEE INSTRUCTIONS)

☐ INDIVIDUAL ☐ CORPORATION ☐ PARTNERSHIP* ☐ S CORPORATION* ☐ LLC* ☐ CHARITABLE ORGANIZATION* ☐ FINANCIAL INSTITUTION ☐ INSURANCE COMPANY

TAXPAYER/BUSINESS NAME(S) (IF FILING MISSOURI JOINT INCOME TAX RETURN, BOTH SPOUSES' NAMES MUST BE LISTED)	TAXPAYER TELEPHONE NUMBER
TAXPAYER ADDRESS (ADDRESS, CITY, STATE, ZIP CODE)	TAXPAYER IDENTIFICATION NUMBER(S) (SOCIAL SECURITY NUMBER(S))

TYPE OF DONATION (ATTACH REQUIRED DOCUMENTATION)

*REQUIRES SUPPORTING DOCUMENTATION - SEE INSTRUCTIONS

☐ Cash* ☐ Check/Money Order* ☐ Credit Card* ☐ Publicly Traded Stocks/Bonds* ☐ Real Estate*

AMOUNT OF DONATION	AMOUNT OF TAX CREDIT (50% OF THE DONATION)	DATE OF DONATION
CONTRIBUTIONS THAT INCLUDE A BENEFIT	BENEFIT DESCRIPTION	FAIR MARKET VALUE OF THE BENEFIT

TAXPAYER TYPE (*REQUIRES SUPPORTING DOCUMENTATION - SEE INSTRUCTIONS)

☐ INDIVIDUAL ☐ CORPORATION ☐ PARTNERSHIP* ☐ S CORPORATION* ☐ LLC* ☐ CHARITABLE ORGANIZATION* ☐ FINANCIAL INSTITUTION ☐ INSURANCE COMPANY

TAXPAYER/BUSINESS NAME(S)	TAXPAYER TELEPHONE NUMBER
TAXPAYER ADDRESS (ADDRESS, CITY, STATE, ZIP CODE)	TAXPAYER IDENTIFICATION NUMBER(S) (SOCIAL SECURITY NUMBER(S))

TYPE OF DONATION (ATTACH REQUIRED DOCUMENTATION)

*REQUIRES SUPPORTING DOCUMENTATION - SEE INSTRUCTIONS

☐ Cash* ☐ Check/Money Order* ☐ Credit Card* ☐ Publicly Traded Stocks/Bonds* ☐ Real Estate*

AMOUNT OF DONATION	AMOUNT OF TAX CREDIT (50% OF THE DONATION)	DATE OF DONATION
CONTRIBUTIONS THAT INCLUDE A BENEFIT	BENEFIT DESCRIPTION	FAIR MARKET VALUE OF THE BENEFIT

TAXPAYER TYPE (*REQUIRES SUPPORTING DOCUMENTATION - SEE INSTRUCTIONS)

☐ INDIVIDUAL ☐ CORPORATION ☐ PARTNERSHIP* ☐ S CORPORATION* ☐ LLC* ☐ CHARITABLE ORGANIZATION* ☐ FINANCIAL INSTITUTION ☐ INSURANCE COMPANY

TAXPAYER/BUSINESS NAME(S) (IF FILING MISSOURI JOINT INCOME TAX RETURN, BOTH SPOUSES' NAMES MUST BE LISTED)	TAXPAYER TELEPHONE NUMBER
TAXPAYER ADDRESS (ADDRESS, CITY, STATE, ZIP CODE)	TAXPAYER IDENTIFICATION NUMBER(S) (SOCIAL SECURITY NUMBER(S))

TYPE OF DONATION (ATTACH REQUIRED DOCUMENTATION)

*REQUIRES SUPPORTING DOCUMENTATION - SEE INSTRUCTIONS

☐ Cash* ☐ Check/Money Order* ☐ Credit Card* ☐ Publicly Traded Stocks/Bonds* ☐ Real Estate*

AMOUNT OF DONATION	AMOUNT OF TAX CREDIT (50% OF THE DONATION)	DATE OF DONATION
CONTRIBUTIONS THAT INCLUDE A BENEFIT	BENEFIT DESCRIPTION	FAIR MARKET VALUE OF THE BENEFIT

TAXPAYER TYPE (*REQUIRES SUPPORTING DOCUMENTATION - SEE INSTRUCTIONS)

☐ INDIVIDUAL ☐ CORPORATION ☐ PARTNERSHIP* ☐ S CORPORATION* ☐ LLC* ☐ CHARITABLE ORGANIZATION* ☐ FINANCIAL INSTITUTION ☐ INSURANCE COMPANY

TAXPAYER/BUSINESS NAME(S) (IF FILING MISSOURI JOINT INCOME TAX RETURN, BOTH SPOUSES' NAMES MUST BE LISTED)	TAXPAYER TELEPHONE NUMBER
TAXPAYER ADDRESS (ADDRESS, CITY, STATE, ZIP CODE)	TAXPAYER IDENTIFICATION NUMBER(S) (SOCIAL SECURITY NUMBER(S))

TYPE OF DONATION (ATTACH REQUIRED DOCUMENTATION)

*REQUIRES SUPPORTING DOCUMENTATION - SEE INSTRUCTIONS

☐ Cash* ☐ Check/Money Order* ☐ Credit Card* ☐ Publicly Traded Stocks/Bonds* ☐ Real Estate*

AMOUNT OF DONATION	AMOUNT OF TAX CREDIT (50% OF THE DONATION)	DATE OF DONATION
CONTRIBUTIONS THAT INCLUDE A BENEFIT	BENEFIT DESCRIPTION	FAIR MARKET VALUE OF THE BENEFIT

MO 886-4263 (12-12) D8F-10

MISSOURI DEPARTMENT OF SOCIAL SERVICES

RESIDENTIAL TREATMENT AGENCY TAX CREDIT APPLICATION

INSTRUCTIONS

1. Provide the organization's LEGAL name; contact person; email address.
2. Provide the organization's physical address in addition to a P.O. Box (if applicable)
3. Provide the license number listed on the contract with Children's Division.
4. Taxpayer type - place an (X) in the appropriate box and provide supporting documentation indicated if applicable.

   Supporting Documentation:

   Partnerships, S Corporations and LLC's please provide a list of all shareholder names; social security numbers, and percentage of ownership.

   Charitable organizations applying for tax credits under Section 135.1150, RSMo, must provide:

   - proof the organization is exempt from federal income tax (copy of federal tax exemption certificate), and
   - proof of business activities that are unrelated to its charitable activities of which Missouri unrelated business taxable income, if any, would be subject to the state income tax imposed under chapter 143, RSMo (i.e. most recent Missouri State Income Tax Return). If the unrelated business activities do not generate Missouri business taxable income, an Executive Officer of the organization must provide an attestation indicating the organization's unrelated business activities do not generate taxable business income but if there were taxable business income, that income would be subject to the state tax imposed under chapter 143, RSMo (attach the Charitable Organization Attestation Form to the application).
5. Taxpayer name should be the complete name submitted on annual income tax returns.
6. Taxpayer identification is either the tax identification number or social security number.
7. Identify the type of donation made and provide supporting documentation (if applicable).

   Verifying documentation must be attached to the tax credit application. The type of documentation required will depend on the type of donation. Required documentation includes the following:

   - Cash – legible receipt from the Residential Treatment Agency which indicates the name and address of the organization; name, address and telephone number of the contributor; amount of the cash donation and the date the contribution was received; signature of a representative of the Residential Treatment Agency receiving the contribution.
   - Check – photocopy of the cancelled check, front and back - if not possible then a copy of the original check and a receipt from the Residential Treatment Agency including the same information required of a cash donation.
   - Credit Card – legible transaction receipt with the name and address of the Residential Treatment Agency; name, address, and telephone number of the contributor; amount and the date the contribution was received; signature of a representative of the Residential Treatment Agency receiving the contribution. Receipts should have the credit card account number blacked out.
   - Money order or cashier's check – legible copy of the original document with the name and address of the Residential Treatment Agency, name, address and telephone number of the contributor; amount of the donation and the date the contribution was received;
   - Values of publicly traded stocks and bonds must be determined by a reputable source (e.g. Wall Street Journal, NYSE, NASDAQ, etc.) Information required when submitting applications for tax credit shall include the source and date the stock was valued and how the bond amount was determined; and confirmation documentation of the transfer from the contributor's account to the qualifying residential treatment agency.
   - The values of contributions of real estate shall be equal to the lowest of at least two (2) qualified independent appraisals for commercial, vacant or residential property that has been determined to have a value of over $25,000. Commercial, vacant or residential property having a value of $25,000 or less will require only one (1) appraisal.
   - Contributions that include a benefit to the donor – documentation required will depend on how the type of contribution was made (i.e. cash, check, etc.). The same information is required as described for those types of donations listed above. Additional information required includes the type of function or event from which the benefit was received, description of the benefit received (if an auction item, identify the item received), gross amount of the contribution, fair market value of the benefit, and how the fair market value of the benefit was determined.
8. Amount of donation is the total funds received or the total value of the donation after the fair market value of any benefit received is deducted (the eligible tax credit will be 50% of this amount).
9. Amount of tax credit is equal to 50% of the donation(s) received.
10. Number of certificates should be the total number of certificates requested to be issued.
11. Total amount of tax credits requested should be the total of the individual amounts submitted for each taxpayer. Submit payment to the Department of Social Services equal to this amount.
12. All applications and supporting documentation must be submitted to the Residential Treatment Agency listed for complete processing.

MO 886-4263 (12-12)

DBF-10

MISSOURI DEPARTMENT OF SOCIAL SERVICES

CHARITABLE ORGANIZATION ATTESTATION

"I certify that _____ engages in unrelated business
(ORGANIZATION NAME)

activities of which do not generate Missouri unrelated business taxable income. If these activities did generate Missouri unrelated business taxable income, that income would be subject to the state income tax imposed under chapter 143, RSMo."

SIGNATURE	
PRINTED NAME	
TITLE	DATE

MO 886-4263 (12-12)

MISSOURI DEPARTMENT OF SOCIAL SERVICES

TAX CREDIT TRANSFER

The Department of Social Services (DSS) tax credit transfer form must be used when transferring eligible tax credits administered by the DSS. You must submit a separate Tax Credit Transfer form for each tax credit transfer being requested. The sale or transfer of a tax credit may have income tax consequences for the assignor and assignee. Consult your tax advisor for more information.

ASSIGNOR

NAME OF ASSIGNOR	ASSIGNOR TELEPHONE NUMBER
ASSIGNOR ADDRESS	
ASSIGNOR TAXPAYER IDENTIFICATION NUMBER (SOCIAL SECURITY NUMBER)	

TRANSFER

TAX CREDIT TYPE

☐ PREGNANCY RESOURCE CENTER TAX CREDIT ☐ RESIDENTIAL TREATMENT AGENCY TAX CREDIT ☐ DEVELOPMENTAL DISABILITY CARE PROVIDER TAX CREDIT

APPROVED CERTIFICATE NUMBER	(OFFICE USE ONLY)	
VALUE OF TAX CREDIT (SEE INSTRUCTIONS)	DATE OF TRANSFER	TAX CREDIT SELLING PRICE (SEE INSTRUCTIONS)

CERTIFICATION

ASSIGNOR SIGNATURE	DATE
PRINTED NAME	(OFFICE USE ONLY)

ASSIGNEE

NAME OF ASSIGNEE	ASSIGNEE TELEPHONE NUMBER
ASSIGNEE ADDRESS	
ASSIGNEE TAXPAYER IDENTIFICATION NUMBER (SOCIAL SECURITY NUMBER)	

TAXPAYER TYPE (*REQUIRES SUPPORTING DOCUMENTATION - SEE INSTRUCTIONS)

☐ Individual ☐ Corporation ☐ Partnership* ☐ S Corporation* ☐ LLC* ☐ Charitable Organization*
☐ Financial Institution ☐ Insurance Company

CERTIFICATION

ASSIGNEE SIGNATURE	DATE
PRINTED NAME	(OFFICE USE ONLY) REISSUE CERTIFICATE NUMBER

NOTARY PUBLIC EMBOSSER SEAL	STATE OF	COUNTY (OR CITY OF ST. LOUIS)
	NOTARY PUBLIC NAME	MY COMMISSION EXPIRES
	NOTARY PUBLIC SIGNATURE	
	USE RUBBER STAMP IN AREA BELOW	

Appeared before me on this _____ day of _____, 20____, _____

and _____ to me personally known to be the persons who executed the above certifications, and acknowledged and states that he/she executed the same for the purpose therein stated.

MO 886-4386 (9-12)

MISSOURI DEPARTMENT OF SOCIAL SERVICES

TAX CREDIT TRANSFER

Information provided below must include all individuals listed on the original tax credit certificate.

1. Provide the Assignor's LEGAL name. The Assignor is the person transferring ownership of the tax credit (e.g. the seller).

2. Provide the Assignor's complete address including city, state and zip code.

3. Provide the Assignor's taxpayer identification number or social security number.

4. Indicate the type of tax credit certificate being transferred (i.e. Pregnancy Resource Center, Developmental Disability Care Provider or Residential Treatment Agency tax credit).

5. Provide the original tax credit certificate number.

6. Provide the value of the tax credit on the date of transfer. This is the amount of the approved tax credit or, if some portion of the tax credit was previously used, this is the value of the remaining tax credit.

   Example: In 2007 a tax credit certificate was issued for $2,000. In 2007 the value of the tax credit is $2,000. If that year the taxpayer was able to claim $500 of that credit; the value of the remaining tax credit carried over to the next tax year was $1,500. If the tax credit was sold or transferred during 2008, the value of the tax credit would be $1,500.

7. Provide the date of transfer.

8. Provide the selling price.

   Note: The following criteria applies only to the transfer of a Pregnancy Resource Center tax credit certificate:

   The tax credit must be transferred or sold...

   (1) For no less than seventy-five percent of the par value of such credit; (Par value meaning the value of the tax credit at the time of transfer); and
   (2) In an amount not to exceed one hundred percent of annual earned credit.

   Example: Using the scenario in #6 above. The value of the credit being transferred is $1,500. It can not be sold for less than 75% of that amount or no less than $1,125. A taxpayer can not sell or transfer tax credit in any given year in an amount that exceeds 100% of the annual earned credit, which is $1,500. Therefore, if in 2008 the taxpayer has the $1,500 carryover and earns another $2,000 tax credit for 2008, the taxpayer can only sell or transfer tax credits up to $2,000. The taxpayer can not sell or transfer tax credits in excess of the annual earned credit ($2,000) in any given year.

9. Provide the Assignor's Signature, date of signature and printed name.

10. Provide the Assignee's LEGAL name as it appears on annual income tax returns. The Assignee is the individual purchasing or receiving the tax credit (e.g. the buyer).

11. Provide the Assignee's complete address including city, state and zip code.

12. Provide the Assignee's taxpayer identification number or social security number.

13. Indicate the Assignee's Taxpayer type - place an (X) in the appropriate box and provide supporting documentation indicated if applicable.

    Supporting Documentation:

    Partnerships, S Corporations and LLC's please provide a list of all shareholder names; social security numbers, and percentage of ownership.

MO 886-4386 (9-12)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
TAX CREDIT TRANSFER

Charitable organizations applying for tax credits must provide:

- proof the organization is exempt from federal income tax (copy of federal tax exemption certificate), and
- proof of business activities that are unrelated to its charitable activities of which Missouri unrelated business taxable income, if any, would be subject to the state income tax imposed under chapter 143, RSMo (i.e. most recent Missouri State Income Tax Return). If the unrelated business activities do not generate Missouri business taxable income, an Executive Officer of the organization must attest to the following statement:

"I certify that _____ engages in unrelated
(ORGANIZATION NAME)

business activities which do not generate Missouri unrelated business income. If these activities did generate Missouri unrelated business income, that income would be subject to the state tax imposed under chapter 143, RSMo."

SIGNATURE	TITLE	DATE

14. Provide the Assignee's Signature, date of signature and printed name.
15. The completed tax credit transfer form must be notarized. If both the assignor and assignee can not be present at the time of the notarized endorsement, each individual may have a copy of the document notarized individually. However, both copies must be submitted to the Department of Social Services at the same time.
16. Forward the transfer form and all supporting documentation required to the following address:

Residential Treatment Agency Tax Credit Transfers:

Department of Social Services
Attention: Residential Treatment Agency Tax Credit
P.O. Box 853
Jefferson City, MO 65102-0853

Pregnancy Resource Center Tax Credit Transfers:

Department of Social Services
Attention: Pregnancy Resource Center Tax Credit
P.O. Box 863
Jefferson City, MO 65102-0863

Developmental Disability Care Provider Tax Credit Transfers:

Department of Social Services
Attention: Developmental Disability Care Provider Tax Credit
PO Box 853
Jefferson City, MO 65102-0853

MO 886-4386 (9-12)

*AUTHORITY: section 135.1150, RSMo Supp. [2006] **2012**. Emergency rule filed Sept. 18, 2006, effective Oct. 1, 2006, expired March 29, 2007. Original rule filed Sept. 18, 2006, effective March 30, 2007. Amended: Filed Feb. 25, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Children's Division, Candace Shively, Director, PO Box 88, Jefferson City, MO 65103. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order or rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety-(90-) day period during which an agency shall file its order of rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the proposed rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 100—Office of Quality Schools

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 160.514, 160.526, and 167.131, RSMo 2000, and sections 160.518, 161.092, 162.081, and 168.081, RSMo Supp. 2012, the board adopts a rule as follows:

5 CSR 20-100.255 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on November 1, 2012 (37 MoReg 1571–1582). Changes have been made to the text of Appendix A and fiscal note, so it is reprinted here. This proposed rule becomes effective **January 22, 2015**.

SUMMARY OF COMMENTS: The State Board of Education (board) received five thousand five hundred nine (5,509) comments regarding the proposed rule.

Agency Note: Due to the volume of comments received relating to 5 CSR 20-100.255 Missouri School Improvement Program–5 (MSIP-5) Resource and Process Standards and Indicators, the Department of Elementary and Secondary Education (department) was unable to publish a list of individuals commenting on this rule. The department maintains a copy of all individual comments which are available upon request. Requests should be made to the Custodian of Records, Office of the General Counsel and Governmental Affairs, Department of Elementary and Secondary Education, PO Box 480, Jefferson City, MO 65102-0480.

COMMENT #1: Two (2) comments were received requesting hearings regarding the resource and process standards.
RESPONSE: The department does not plan to hold a hearing on the Resource and Process Standards and Indicators. An advisory committee consisting of seventy (70) members, representing teachers, administrators, parents, school board members, and others, met four (4) times and participated in webinars to review and make recommendations to the board prior to the original submission of the proposed rule.

COMMENT #2: One (1) comment was received requesting specific language defining comprehensive health instruction in Standard R-1 Elementary and Standard R-2 Junior High/Middle School.
RESPONSE: The board reviewed the comment and the specific components of the comprehensive health instruction are not included to allow for timely implementation of current health issues. No changes are made to Standard R-1 and Standard R-2.

COMMENT #3: Seven (7) comments were received requesting a definition of "moderate physical activity."
RESPONSE: The board reviewed the comment and a formal definition is not provided as districts should remain consistent with the language in section 167.720, RSMo.

COMMENT #4: Two (2) comments were received to expand physical education class size at the junior high level in Standard R-2 Junior High/Middle School.
RESPONSE: The board reviewed the comment and declines to make this change. Districts may utilize the standard outlined for 7-12 classrooms for junior high physical education class size.

COMMENT #5: Two thousand twenty-four (2,024) comments recommended rewording the language in Standard R-3 High School to indicate that career-technical education courses offered must be department-approved.
RESPONSE AND EXPLANATION OF CHANGE: The board agrees to make this change to Standard R-3.

COMMENT #6: One thousand eight hundred fifteen (1,815) comments were received requesting specific requirements for course offerings be outlined in Standard R-3 High School as is written in the 4th Cycle MSIP Standards and Indicators. Of these comments, one thousand three hundred forty-two (1,342) specifically requested that a minimum standard requirement of twelve (12) units of credit and a desirable standard requirement of twenty (20) units of credit for career-technical education courses be outlined. Three hundred ninety-nine (399) of these comments recommended greater specificity for required electives in the district's high school course offerings. Numerous comments were received from superintendents and educational organizations supporting the flexibility afforded districts in meeting the specific needs of students and their communities with the removal of minimum and desirable course offering requirements as presented in the proposed standards.
RESPONSE AND EXPLANATION OF CHANGE: The board agrees to revise Standard R-3 High Schools to include "department-approved" in reference to career-technical education, as described in COMMENT #5, and to include agricultural education in the list of content areas to be offered as appropriate through this standard. The board declines to reinstate required number of high school course offerings in its entirety. As written, Standard R-3 High School provides additional local control of curriculum offerings at the high school level. Though the number of course offerings is no longer defined by the number of units, the importance of the content in each

area of study is not diminished.

COMMENT #7: One hundred thirty-four (134) comments were received indicating a concern that career-technical education programs would be eliminated if local school districts are given flexibility in Standard R-3 High School.
RESPONSE: Changes to the Resource and Process Standards are designed to provide increased local control to districts, allowing parents, community leaders, school boards, administrators, and students to decide the courses that are needed to ensure that their students graduate college and career ready. Though the number of course offerings is no longer defined by the number of units, the importance of the content in each area of study is not diminished and career-technical education remains a content area identified in Standard R-3 High School.

COMMENT #8: Twenty-four (24) comments were received requesting that dual enrollment be added to Standard R-3 Indicator 2 as part of the examples listed for postsecondary preparation.
RESPONSE AND EXPLANATION OF CHANGE: The board agrees to and makes this change to Standard R-3 Indicator 2 consistent with the MSIP-5 Performance Standards.

COMMENT #9: Two (2) comments were received opposing the assignment of forty-five (45) students to high school physical education courses in Standard R-3 High School.
RESPONSE: The board declines to change this class size at the high school level. This is consistent with prior cycle of the Missouri School Improvement Program (MSIP). The advisory committee addressed the issue of class size for physical education at the high school by including language that appropriate supervision and facilities are provided.

COMMENT #10: Three (3) comments were received requesting that career-technical school and high school articulation agreements be added to Standard R-3 High School Indicator 2 as part of the examples listed for postsecondary preparation.
RESPONSE: The board declines to make this change, as items that are included are simply examples.

COMMENT #11: One (1) comment was received regarding the lack of specificity related to paraprofessionals in Standard R-4 Class Size and Assigned Enrollments, Option 1.
RESPONSE AND EXPLANATION OF CHANGE: The board agrees to revise Standard R-4, Option 1 to reflect class-size reduction utilizing paraprofessionals.

COMMENT #12: Three (3) comments were received indicating that districts felt they would not be able to attain the desirable standard in MSIP-5 for Standards R-1 Elementary, R-4 Class Size and Assigned Enrollments, R-6 Guidance and Counseling Staff, and R-9 Principals/Building Administrators due to financial constraints.
RESPONSE: The board declines to make a change. The numbers presented reflect a desirable goal; districts are not required to meet the desirable standard.

COMMENT #13: One (1) comment was received requesting to cap enrollment in Career Technical Education (CTE) courses in Standard R-4 Class Size and Assigned Enrollments at twenty (20)—fifteen (15) for classes that involve the use of hazardous tools—and to create a program ratio (student to teacher) for each program.
RESPONSE: The board declines to make this change. Local boards of education have the flexibility to establish these standards as part of district policy.

COMMENT #14: Two (2) comments were received regarding the accuracy of Standard R-9 Principals/Building Administrators for both the standard and desirable standard.
RESPONSE AND EXPLANATION OF CHANGE: The ratios presented for the proposed standard and desirable standard as originally presented in the *Missouri Register* were inaccurate. The board agrees to make this correction and to use the numbers recommended by the advisory committee. The accurate numbers are included in the revised Appendix A, public cost statement, and fiscal note. This change reflects a reduction of $104,435,976 in the original fiscal note.

COMMENT #15: Thirty-four (34) comments recommended maintaining the 4th Cycle MSIP Principals/Building Administrators standard and desirable standard due to the cost of providing additional staff.
RESPONSE: The board declines to make this change. The MSIP-5 R-9 principals/building administrators to student ratios are based on the advisory committee's recommendation to promote the administrator's capacity to focus on instructional responsibilities, including the implementation of the learning and educator standards.

COMMENT #16: One (1) comment was received regarding the accuracy of the statutory citation in Teacher/Leader Standard TL-1.
RESPONSE AND EXPLANATION OF CHANGE: The board agrees to revise Standard TL-1 to reflect the correct citation section 160.045, RSMo.

COMMENT #17: One (1) comment was received to modify Teacher/Leader Standard TL-2, Indicator 6 to include time within the contract day and in addition to individual planning time.
RESPONSE: The board declines to make this change. Local districts are responsible for making a determination about the utilization of contract time.

COMMENT #18: Four (4) comments were received regarding the inclusion of prekindergarten (PK) in Instruction Standards I-1, I-5, and I-6 as an interpretation that districts are required to provide PK services. One (1) comment was received requesting the omission of Governance Standard G-10 related to access to high quality early learning experiences.
RESPONSE AND EXPLANATION OF CHANGE: The board agrees to revise Standard I-6 to omit PK for clarity. The board agrees to make changes for clarity related to provision of comprehensive literacy instruction in PK in Standard I-1. Additionally, the board agrees to make changes to I-5 related to the inclusion of PK teachers in the curriculum development and revision process. While districts are not required to operate PK programs, the original language was included to convey that districts with a PK program should ensure its quality. The board declines to omit G-10.

COMMENT #19: One (1) comment was received asking that "innovative instructional practices" be added to "evidence based" in Instruction Standard I-1, Indicators 3 and 9.
RESPONSE: The board reviewed the comment and declines to make this change. Local boards of education have the flexibility to allow for and encourage innovative practices.

COMMENT #20: Fifty-four (54) comments were received requesting that language specific to the provision of services to gifted students as written in 4th cycle MSIP be included.
RESPONSE AND EXPLANATION OF CHANGE: Instruction Standard I-3 incorporates components of 4th cycle MSIP 7.2 and addresses differentiated instruction for all populations of students, including gifted students. The philosophy provides a comprehensive view applying the context of each student and all student populations. The advisory committee addressed the issue of special student populations, including gifted students, through careful use of the term "all" students. All students represents gifted students, special education students, free/reduced students, limited English proficiency students, etc. Additional language was added to Standard R-1, R-2, and R-3 to

provide that districts may provide state-approved gifted education programs.

COMMENT #21: One (1) comment was received regarding specificity of administrator's role in curriculum development and revision.
RESPONSE AND EXPLANATION OF CHANGE: The board agrees to revise Instruction Standard I-5, Indicators 5 and 6 to reflect the administrator's role.

COMMENT #22: One (1) comment was received requesting the removal of "guaranteed" from Instruction Standard I-5.
RESPONSE: The board declines to make this change. Current research supports the impact of a guaranteed curriculum as a factor in improving student performance.

COMMENT #23: Three (3) comments were received requesting an additional indicator requiring school districts to employ a school psychologist as part of Instruction Standard I-6 the guidance and counseling standard.
RESPONSE: The board declines to make this change. Local boards of education have the flexibility to hire staff appropriate to meet the needs of their district.

COMMENT #24: One (1) comment recommended rewording Instruction Standard I-9, Indicator 1 for clarity.
RESPONSE AND EXPLANATION OF CHANGE: The board agrees to make the change to Standard I-9, Indicator 1.

COMMENT #25: Seven hundred two (702) comments recommended rewording Instruction Standard I-9, Indicator 1 to indicate that career technical education courses offered must be department-approved.
RESPONSE AND EXPLANATION OF CHANGE: The board agrees to make this change to Standard I-9, Indicator 1.

COMMENT #26: Six hundred fourteen (614) comments were received regarding the concern that revisions made in MSIP-5 would result in the loss of Career-Technical Student Organizations (CTSO).
RESPONSE: Instruction Standard I-9, Indicator 4 as proposed for MSIP-5 remains as originally written which requires the appropriate CTSOs for the corresponding, department-approved programs, and course offerings.

COMMENT #27: Four (4) comments were received related to Instruction Standard I-10 Library Media Centers. Two (2) comments were related to the inclusion of librarians in planning time requirements, one (1) comment was related to the reduction of the librarian to student ratio, and one (1) comment was received related to changing the name to reflect changes made in certification.
RESPONSE: The board declines to make changes to Standard I-10. Local boards of education have the flexibility to address these issues.

COMMENT #28: Forty-seven (47) comments were received regarding the development of a fine arts and physical education process standard that defines adequate instruction as a requirement for MSIP-5 accreditation.
RESPONSE: The standards included in Instruction Standards I-1 through I-5 are designed to define adequate instruction for all content areas. The board agreed to maintain the Resource and Process Standards as a formal rule, accreditation recommendations are based on the performance standards. Adequate instruction in fine arts (art and music) and physical education will be recommended as criteria to be utilized in the determination of the Accredited with Distinction classification level.

COMMENT #29: Three (3) comments were received related to Instruction Standard I-11, Indictor 3 and 6 to define equitable access and the technology required to support current assessment practices.
RESPONSE: The board reviewed the comments and determined that the local boards of education will define equitable access to technology. Best practice upholds districts maintaining technology that supports current assessment practices.

COMMENT #30: Two (2) comments were received to change "appropriate certification" to "certificated in these fields" as in 4th cycle MSIP.
RESPONSE: The board declines to make this change. This language is consistent with current terminology and practice.

COMMENT #31: Eleven (11) comments were received asking that the Resource and Process Standards, particularly fine arts and physical education, be requirements for a district's accreditation. Two (2) comments were received requested that the standards continue to be used as best practices rather than requirements.
RESPONSE: The board agreed to maintain the resource and process standards as a formal rule, accreditation recommendations are based on the performance standards.

COMMENT #32: One (1) comment from the Missouri School Boards Association was received incorporating seventy (70) technical and formatting revisions.
RESPONSE AND EXPLANATION OF CHANGE: Technical and formatting revisions were made to the following standards and indicators—R-4, TL-1, TL-2, I-1, I-2, I-3, I-5, I-6, I-7, I-8, I-9, G-1, G-2, G-4, G-6, G-7, G-8, and G-11.

COMMENT #33: One (1) comment was received asking that "meaningful" be added before "collaboration" in Governance G-2, Indicator 1.
RESPONSE: The board declines to make this change. Local districts determine whether or not collaboration is meaningful based on the processes established for this work.

COMMENT #34: Two (2) comments were received related to formal contact regarding the board and district staff in Governance Standard G-7.
RESPONSE: The board declines to make this change. Best practice would dictate that communication with the board should be channeled through the superintendent.

COMMENT #35: One (1) comment was received requesting clarification that the Resource and Process Standards applied to all public schools districts in the state, not just K-12 school districts.
RESPONSE AND EXPLANATION OF CHANGE: The board agrees to make this change to Appendix A for both Resource and Process Standards.

5 CSR 20-100.255 Missouri School Improvement Program–5 Resource and Process Standards and Indicators

APPENDIX A
Missouri School Improvement Program
MSIP–5 Resource and Process Standards and Indicators

RESOURCE STANDARDS FOR MISSOURI PUBLIC SCHOOL DISTRICTS

R-1—Elementary (typically self-contained)—Each elementary student receives regular instruction in English language arts, mathematics, science, social studies, comprehensive health, art, music, and physical education. In K-8 elementary schools, students will have access to a total of four (4) exploratory classes.

1. Each elementary student will receive regular instruction in English language arts, mathematics, science, social studies, comprehensive health, and career awareness education. Instruction in each of the core areas will reflect the current version of Missouri's academic standards.

2. Each elementary student will receive instruction in art, music, and physical education for a minimum of fifty (50) minutes in each area each week (twenty-five (25) minutes in each area for half-day kindergarten classes). These classes shall be taught by teachers with appropriate certification.

3. If the district is a K-7 or K-8 elementary district, the following must also be addressed:

   a. Beginning no later than seventh grade, regular instruction in the *United States* and *Missouri Constitutions* and American History and Institutions will be provided (as required by section 170.011, RSMo).

   b. Students in grades 7-8 will have access to a total of four (4) exploratory classes (e.g., speech, agriculture, family and consumer sciences, industrial technology, world languages, and computer literacy). Each class is taught for a minimum of one thousand two hundred (1,200) minutes each year.

4. Elementary school students shall have a minimum of one (1) recess period of twenty (20) minutes per day, which may be incorporated into the lunch period (as required by section 167.720, RSMo).

5. The school district ensures that students in elementary schools participate in moderate physical activity for the entire school year for an average of one hundred fifty (150) minutes per week, or thirty (30) minutes per day. Students with disabilities must participate to the extent appropriate (as required by section 167.720, RSMo).

6. School districts may offer virtual instruction (e.g., intranet and Internet methods) that may take place outside of the regular school district facility (as described by section 162.1250, RSMo).

7. School districts may offer department-approved gifted education services (as described by sections 167.675, RSMo, 162.720, RSMo, and 163.031.4(7)(c), RSMo).

R-2—Junior High/Middle School (typically departmentalized)—Each junior high/middle school student will receive regular instruction in English language arts, mathematics, science, social studies, career education, health, and physical education and will have access to art and music plus four (4) exploratory classes. Students in grades 7-8 will have regular instruction in *United States* and *Missouri Constitutions* and American History and Institutions.

1. English language arts, mathematics, science, and social studies are scheduled and taught to all students for at least nine hundred (900) minutes each week in the aggregate (or one thousand eight hundred (1,800) minutes every two (2) weeks).

2. Physical education is scheduled and taught to all students for a minimum of three thousand (3,000) minutes each year and comprehensive health and safety education is scheduled and taught to all students for a minimum of one thousand five hundred (1,500) minutes each year.

3. Art and music are scheduled and taught so that all students have access to each for a minimum of one thousand five hundred (1,500) minutes each year.

4. Students in grades 7-8 will have access to a total of four (4) exploratory classes (e.g., speech, agriculture, family and consumer sciences, industrial technology, world languages, and computer literacy). Each class is taught for a minimum of one thousand five hundred (1,500) minutes each year.

5. Beginning no later than seventh grade, regular instruction in the *United States* and *Missouri Constitutions* and American History and Institutions will be provided (as required by section 170.011, RSMo).

6. School districts may offer virtual instruction (e.g., intranet and Internet methods) that may take place outside of the regular school district facility (as described by section 162.1250, RSMo).

7. School districts may offer department-approved gifted education services (as described by sections 167.675, RSMo, 162.720, RSMo, and 163.031.4(7)(c), RSMo).

R-3—High School—Each high school provides all students in grades 9-12 sufficient access to content required to meet the minimum graduation credit requirements and meets the specific needs of students and communities. Content areas must include: English language arts, mathematics, science, department-approved career education (e.g., agriculture education), social studies, world languages, fine arts (art and music), physical education, health, practical arts, and personal finance, as appropriate for each high school.

1. School districts may offer virtual instruction (e.g., intranet and Internet methods) that may take place outside of the regular school district facility (as described by section 162.1250, RSMo).

2. Students will have access to postsecondary preparation (e.g., Advanced Courses, Advanced Placement, International Baccalaureate, Technical Skills Attainment, Dual Enrollment, and Dual Credit).

3. School districts may offer department-approved gifted education services (as described by sections 167.675, RSMo, 162.720, RSMo, and 163.031.4(7)(c), RSMo).

R-4—Class Size and Assigned Enrollments—Enrollments will be consistent with both class-size and program standards and total enrollment requirements.

1. Student enrollment in individual classes will be consistent with the following guidelines:

GRADES	*STANDARD*	*DESIRABLE STANDARD*
K-2	25	17
3-4	27	20
5-6	30	22
7-12	33	25

2. Full-time elementary art, music, and physical education shall serve no more than seven hundred fifty (750) students per week.

Options:

1. Student enrollment in a classroom may increase by as many as ten (10) students for any period that a paraprofessional assists the classroom teacher full time, or by as many as five (5) students when a paraprofessional assists the teacher half time. (Paraprofessionals paid for with Title I and special education funds cannot be used to increase class size. See the Consolidated Federal Programs Administrative Manual for guidelines on compliance and the use of paraprofessionals for Title I purposes).
2. Elementary school classes may enroll students from two (2) consecutive grade levels. Total enrollment in such classes shall not exceed the class-size standards listed above for the lowest grade included in the combination.
3. High schools can combine sections of a same subject in beginning and advanced levels (e.g., Spanish I and Spanish II or Spanish III and Spanish IV). Total combined enrollment in such classes shall not exceed twenty-five (25) students.
4. Enrollment in performing arts classes may exceed regular class-size limits if adequate supervision and facilities are provided.
5. High school physical education classes may enroll up to forty-five (45) students if appropriate supervision and facilities are provided.

R-5—Library Media Staff—Certificated librarians and/or library media specialists are assigned consistent with the following ratios, based on the student enrollment at each building.

STANDARD		*DESIRABLE STANDARD*	
Students	FTE	Students	FTE
1-200	.20	1-150	.20
201-400	.40	151-300	.40
401-600	.60	301-450	.60
601-800	.80	451-600	.80
801-1000	1.00	601-750	1.00
1001-1200	1.20	751-900	1.20
1201-1400	1.40	901-1050	1.40
1401-1600	1.60	1051-1200	1.60
1601-1800	1.80	1201-1350	1.80
1801-2000	2.00, etc.	1351-1500	2.00, etc.

R-6—Guidance and Counseling Staff—Certificated counselors are assigned consistent with the following ratios, based on the student enrollment at each building.

STANDARD		*DESIRABLE STANDARD*	
Students	FTE	Students	FTE
1-100	.20	1-50	.20
101-200	.40	51-100	.40
201-300	.60	101-150	.60
301-400	.80	151-200	.80
401-500	1.00	201-250	1.00
501-600	1.20	251-300	1.20
601-700	1.40	301-350	1.40
701-800	1.60	351-400	1.60
801-900	1.80	401-450	1.80
901-1000	2.00, etc.	451-500	2.00, etc.

R-7—Superintendent—A certificated superintendent is assigned to serve full-time as the district's chief administrative officer.

Options:

1. For a period of one (1) year, any two (2) adjacent districts, that are classified "accredited," may upon prior approval from the Department of Elementary and Secondary Education (department) share a superintendent who possesses a valid Missouri superintendent's certificate. Any two (2) such districts which wish to share a superintendent for more than one (1) year shall obtain prior approval from the State Board of Education (board).

2. A superintendent of schools in a district which employs twenty-five (25) certificated Full Time Equivalent (FTE) or fewer must hold a valid Missouri superintendent's certificate and may serve as the elementary or secondary principal, regardless of principal certification type.

3. Elementary districts (K-8) with over twenty-five (25) certificated FTE must employ a certificated superintendent as chief administrative officer. Elementary districts with twenty-five (25) certificated FTE or fewer may employ either a certificated superintendent or certificated elementary principal as chief administrative officer.

R-8—Associates/Assistants to the Superintendent—Associates/assistants to the superintendent in the areas of curriculum and instruction must have, as a minimum, a master's degree and a valid Missouri teaching certificate. All other associates/assistants to the superintendent should have appropriate training in their field.

	STANDARD
Certificated Staff Members (FTE)	Assistants to Superintendent (FTE)
1-100	0
101-200	1
201-300	2
301-400	3
401-500	4
501-600	5
601-700	6
701-800, etc.	7, etc.

Assistant superintendents must have a master's degree and a valid Missouri teaching certificate if their primary responsibilities involve curriculum and instruction. Other assistant superintendents should have training in their field (e.g., Masters in Business Administration might be appropriate for an assistant superintendent of finance). Please note that there is no reference to title in this requirement. Districts may elect to call these positions associate superintendents, deputy superintendents, assistant superintendents, assistants to the superintendent, coordinators, or directors.

R-9—Principals/Building Administrators—Certificated principals, career education directors, and assistant administrators are employed and assigned consistent with the MSIP-5 staff ratios.

STANDARD		*DESIRABLE STANDARD*	
Students	FTE	Students	FTE
1-400	1.00	1-300	1.00
401-600	1.50	301-450	1.50
601-800	2.00	451-600	2.00
801-1000	2.50	601-750	2.50
1001-1200	3.00	751-900	3.00
1201-1400	3.50	901-1050	3.50
1401-1600	4.00	1051-1200	4.00
1601-1800	4.50	1201-1350	4.50
1801-2000	5.00	1351-1500	5.00
2001-2200	5.50	1501-1650	5.50
2201-2400	6.00	1651-1800	6.00

R-10—Certification and Licensure—All personnel must hold a valid certificate or license appropriate for each assignment.

R-11—Planning Time—Each full-time classroom teacher, including kindergarten teachers, shall have a minimum of two hundred fifty (250) minutes of scheduled planning time each school week. It is desirable to have fifty (50) minutes of planning time each day. Planning time is calculated between the official start and close of the school day and does not include travel time, lunch time, or time before or after school. (Planning time is not required for administrators, counselors, or librarians.)

PROCESS STANDARDS FOR MISSOURI PUBLIC SCHOOL DISTRICTS

TEACHER/LEADER

TL-1—The district develops and implements teacher/leader standards designed to ensure effective instructional staff for all students.

1. The district adopts and implements an educator evaluation system that is aligned to the essential principles of effective evaluation, adopted by the state board of education, designed to ensure effective teachers and leaders.
2. The district develops and implements professional teacher standards as required by section 160.045, RSMo.
3. The district develops and implements professional leader standards.
4. Teachers and leaders apply professional judgment and use the teacher/leader standards developed by the district to inform and improve practice.

TL-2—Professional learning drives and supports instructional practices in the district and leads to improved student learning.

1. All staff participate in regularly scheduled, ongoing professional learning focused on student performance goals as outlined in the Comprehensive School Improvement Plan (CSIP).
2. Professional learning is an ongoing process that occurs in the context of all instructional staff positions and promotes the use of evidence-based instructional practices.
3. District leaders monitor teachers for consistent implementation of effective practices, as designed by routinely observing, monitoring, and supervising classroom instruction.
4. Effective practices are monitored for fidelity of implementation through observation and supervision of classroom practices.
5. The district regularly monitors instructional employees to determine whether professional learning is implemented in classroom instruction and demonstrates positive impact on student learning.
6. School-based collaborative teams are in place and focus on data informed decision-making, reflective practices, collaborative lesson design, examination of student work and student assessment, curriculum development, positive classroom learning environments, utilization of case studies, and action research.
7. The district has a written procedural plan for professional learning that includes the required components.
8. The district provides time and resources for the professional learning of each staff member.

INSTRUCTION

I-1—Instructional staff routinely provide effective instruction designed to meet the needs of all learners.

1. Instructional staff routinely collaborate and use student data to provide appropriate interventions to address a range of student instructional and behavioral needs.
2. Instruction is routinely differentiated to address the needs of all students.
3. Instructional staff use evidence-based instructional practices to meet the learning needs of all students.
4. Comprehensive K-12 literacy instruction is provided. When Prekindergarten (PK) is offered by the district, comprehensive literacy instruction is provided.
5. All staff are an integral part of the instructional practices in every building.
6. All staff demonstrate effective use of available instructional time.
7. Instructional staff design and use appropriate, meaningful, and rigorous learning tasks for all students.
8. Building leaders demonstrate that supervision of instruction is a priority.
9. The district requires instructional staff to consistently utilize evidenced-based instructional practices as they were designed to be implemented and routinely monitors instructional staff for implementation of these practices.

I-2—Instructional staff use effective assessment practices to monitor student learning and adjust instruction.

1. Instructional staff use both formative and summative assessments to monitor student learning and adjust instruction.
2. Instructional staff regularly and systematically uses assessment results and other student work to make adjustments to curriculum, instruction, and intervention strategies to assist students in meeting state achievement standards.
3. Classroom assessments include the use of higher order thinking and problem-solving skills, as well as complex reasoning skills.
4. Timely, descriptive, and constructive feedback from assessments is provided to students and parents.

I-3—The district identifies and provides effective differentiated learning and behavioral support systems for all students.

1. A written process is in place for the early identification and implementation of differentiated learning and behavioral supports for all students.
2. Learning and behavioral supports are identified and coordinated at the classroom, building, and district level.
3. The district uses a variety of student and program data to monitor, evaluate, and inform decision-making to identify and implement successful learning and behavioral supports.
4. The district collaborates with community partners to provide information and resources to students and parents to address barriers impacting student success, including but not limited to academic, physical, and mental health needs.
5. The district requires instructional staff to consistently implement learning and behavior supports as they were designed. District leaders routinely monitor the implementation of these practices by instructional staff through observation and supervision of classroom instruction.

I-4—The district administers state-required tests and other assessments and uses disaggregated and longitudinal data to inform and adjust systems, curriculum, and instructional practices.

1. The district has a written assessment plan that includes the required components.
2. The district uses a variety of data (e.g., longitudinal, demographic, diagnostic, and perceptual) to support and inform district-wide decisions.
3. The local board of education annually reviews performance data disaggregated for any subgroup of five (5) or more students per assessment in order to effectively monitor student academic achievement and persistence to graduation rates.
4. The district uses disaggregated data to adjust instruction for subgroups and has criteria for evaluating the effectiveness of these adjustments.

I-5—The local board of education adopts and district staff implement, review, and revise a rigorous, guaranteed, and viable curriculum for all instructional courses and programs.

1. The district has a rigorous, written curriculum that includes the required components and is aligned to the most recent version of Missouri's academic standards and the English language development standards.

2. Essential content and skills that all students should know and be able to do have been identified.

3. Adequate instructional time is available to implement the written curriculum.

4. The written, taught, and assessed curriculum are the same.

5. Written procedures are in place and administrators ensure that the written curriculum is implemented and is a part of the district's program evaluation plan.

6. The district's written curriculum development and revision processes include K-12 vertical teams of instructional staff and administrators (including teachers of all student populations) who meet regularly to ensure articulation and vertical alignment. When Prekindergarten (PK) is offered by the district, instructional staff shall be included in the curriculum and development revision processes.

I-6—Guidance and counseling is an essential and fully integrated part of the instructional program.

1. A district-wide guidance and counseling program has been developed and is fully implemented in every building consistent with the Missouri Comprehensive Guidance and Counseling Program framework.

2. The K-12 guidance curriculum is in place, integrated into the regular curriculum where appropriate, and is regularly reviewed and revised as part of the district's evaluation plan.

3. All students, beginning no later than seventh grade, participate in an individual planning process designed to assist in a successful transition to college, technical school, the military, or the workforce.

4. All students have access to responsive services that assist them in addressing issues and concerns that may affect their academic, career, and personal/social needs.

5. System support and management activities are in place to ensure full implementation, evaluation, and continued improvement of the district's comprehensive guidance program.

I-7—The district establishes a culture focused on learning, characterized by high academic and behavioral expectations for all students.

1. A systemic process for establishing and maintaining a positive learning climate is evident in each building.

2. Responsibility for the success of all students is evident in the shared mission and vision of the district.

3. Staff, administrators, and students all share in the accountability for academic achievement by being actively engaged in learning and demonstrating appropriate standards of behavior.

4. Curricular choices and course offerings reflect an increasing and ongoing dedication toward future success of all students.

5. A well-balanced, comprehensive co-curricular and extracurricular activities program is in place and aligned to the mission and vision of the district.

I-8—The district provides a safe and orderly environment for all students and staff.

1. Students and staff indicate that they feel safe at school.

2. The district provides staff, teachers, parents, and students access to the district's written code of conduct, which specifies unacceptable student behavior and consequences for that behavior. The code of conduct is enforced during school, on school property, on district-provided transportation, and during school-sponsored events, regardless of whether the events occur on or off of school property.

3. Standards of conduct are consistently and equitably enforced by all staff.

4. Violence-prevention instruction, including information on preventing and responding to illegal harassment and bullying, has been provided for all students and staff.

5. Data are gathered on student violence, substance abuse, and bullying and are used to modify programs and strategies to ensure safe and orderly schools.

6. Written procedures are in place to proactively identify and prevent potential disruptions to a safe and orderly school climate.

I-9—High quality, fully integrated career education is available to all secondary students.

1. The district has implemented programs of study for each department-approved career education program offered which sequences academics and career education content, leading students to attain a postsecondary degree, an industry-recognized certificate or credential, or entry into the workplace with a skill set conducive toward career advancement.

2. The career education program has a written curriculum for each course with a balance among classroom/laboratory instruction, leadership, and personal learning.

3. Written curriculum drives classroom instruction and assessment of technical skill attainment.

4. The appropriate Career and Technical Student Organization (CTSO) is affiliated with the state and national organization and is an intra-curricular element of the program.

5. A system of data collection and evaluation provides the information necessary for program review and development so that students are prepared for postsecondary success leading to quality employment opportunities.

I-10—Library Media Centers (LMC) are an essential and fully integrated part of the instructional program.

1. The library media center and its resources support, enhance, and enrich the curriculum.

2. The library media staff collaborate with instructional staff to integrate LMC resources and services into the instructional program.

3. Students have access to a full range of information, digital access, and reading resources and services in the LMC.

4. The LMC program is evaluated annually.

I-11—The district advances excellence in teaching and learning through innovative and effective uses of technology.

1. The district has a systemic plan aligned with a shared vision for school effectiveness and student learning through the infusion of information and communication technology (ICT) and digital learning resources.

2. The district provides consistent, adequate, and ongoing support of technology infrastructure, personnel, and digital resources.

3. The district provides equitable and reliable access to current and emerging technologies and digital resources, with connectivity for all students, teachers, staff, and school leaders.

4. The district provides access to ongoing professional learning in technology and opportunities for dedicated time to practice and share ideas.

5. The district evaluates the impact of information and communication technology on teaching and learning.

6. The district maintains technology that supports current assessment practices.

GOVERNANCE

G-1—The local board of education, district leadership, and staff contribute to the success of every student by being ethical and acting with fairness and integrity.

1. The local board of education has adopted and the district leadership enforces a professional code of ethics for all employees.

2. The local board of education has adopted and adheres to its own code of ethics.

3. District policies, procedures, and practices demonstrate respect for students, employees, and others.

G-2—The local board of education adopts and district leadership implements a Comprehensive School Improvement Plan (CSIP) to ensure the achievement and success of all students.

1. The local board of education and district leadership, in collaboration with the community, use qualitative data, quantitative data, and evaluation results to create a written, board-approved CSIP which drives improvement in student learning and guides the overall improvement of its educational programs and services.

2. The school district maintains a current CSIP that includes all of the required components.

3. There is a written evaluation process for the CSIP and the CSIP is regularly evaluated and updated.

4. The local board of education utilizes the CSIP to monitor progress and continuous improvement of programs and services.

G-3—The local board of education and district leadership collect qualitative and/or quantitative data to guide and monitor the development and implementation of a shared mission and vision with systemic goals that ensure high expectations for every student.

1. The local board of education and district leadership, with input from all stakeholders, guide the development of a district-wide, learning-focused mission and vision that are reviewed annually and revised as needed.

2. The local board of education and district leadership hold all staff accountable for continuous school improvement and increased student learning.

G-4—The local board of education and district leadership promote the achievement and success of all students by monitoring and continuously improving all programs and services that support the mission and vision of the district.

1. The board of education regularly reviews, no less than once every two (2) years, the goals, objectives, and effectiveness of all programs and services that support the mission and vision of the district based on data provided by district leadership.

2. The local board of education adopts and the district implements an evaluation plan that analyzes the effectiveness of all programs and services.

3. The district collects perceptual data from students and uses that information to make informed decisions about its programs and services.

4. Patrons, parents, staff, and students have opportunities to serve on committees, including those required by state or federal regulations, to study specific issues and provide feedback on district programs and services.

5. The district reviews and analyzes postsecondary success rates to make informed decisions.

G-5—The district complies with all provisions, regulations, and administrative rules applicable to each state and/or federal program implemented.

G-6—The local board of education and district leadership facilitate collaboration with state and local agencies, non-profit organizations, and other community groups that promote the success, health, safety, and welfare of students.

1. The district identifies programs that promote equitable learning opportunities and success for all students, regardless of socio-economic background, ethnicity, gender, disability, or other individual characteristics.

2. The district collaborates with community leaders to collect, describe, and analyze data on economic, social, and other emerging issues that impact district and school planning, programs, and organization.

3. The district collects and accurately communicates data about educational performance in a clear and timely way to improve policies and inform community decisions.

4. District leadership implements processes to facilitate regular collaboration with other agencies/organizations to respond to student needs in a timely manner.

G-7—The local board of education understands the role and responsibilities of the local board and acts accordingly.

1. Policymaking functions are carried out by the local board of education, while administrative functions are carried out by the superintendent and the staff. All formal contact between the local board of education and the staff is channeled through the superintendent.

2. The local board of education has established policies and written procedures are in place to guide district decision-making and to meet federal and/or state requirements. Policies and procedures are reviewed on a regular basis and reflect current legal requirements.

3. The local board of education meets regularly in accordance with applicable statutes, keeps accurate and complete records of its decisions, and makes the records available as required by law.

4. Members of the local board of education receive training as required by law.

5. Local board of education members participate in continued training and professional learning.

G-8—The local board of education and district leadership manage organizational systems and resources for a safe, high-performing learning environment.

1. The local board of education and the district leadership regularly communicate with district employees and the community regarding the district's vision and mission.

2. District staff use documented evidence (e.g., observations, walkthroughs, collaborative teams, and mentoring) to develop professional growth plans.

3. The community, through the local board of education, provides sufficient financial resources to ensure an educational program of quality.

4. The local board of education has adopted and enforces policies requiring effective fiscal management and accountability and the district leadership implements procedures to support the board's policies.

5. The local board of education and district leadership employ appropriate procedures to ensure the accurate and timely reporting of required data to state and federal agencies.

6. The local board of education and district leadership provide facilities that are healthful, adequate in size, clean, well-maintained, and appropriate to house the educational programs of the district.

7. The local board of education and district leadership ensure all facilities are safe.

8. The district leadership has developed and implemented a coordinated approach to school health services.

9. The district ensures a school nutrition program is available which provides at least one (1) nutritionally balanced meal available to all students each day in accordance with Federal and State Child Nutrition Program regulations and guidelines.

10. The district ensures safe and efficient transportation to and from school is provided in compliance with Missouri statutes, regulations, and local board of education policy.

G-9—The local board of education, district leadership, and staff collaborate with families and community members who represent diverse interests and needs to mobilize community resources that improve teaching and learning.

1. The local board of education, district leadership, and staff systematically and frequently provide information to the public about school programs.

2. The district has procedures to involve family and community members in educational activities.

3. District leadership identifies preschool opportunities available to children and informs family and community members about the importance of early childhood education.

G-10—The district's birth through prekindergarten population will have access to high-quality early learning experiences that will prepare them to succeed in school.

G-11—The district provides opportunities for parents/guardians to learn about the intellectual and developmental needs of their children at all ages and to participate constructively in their children's education.

1. Parent education activities are provided as required by the Early Childhood Development Act (ECDA).

2. The district actively cooperates with other agencies and parent and community groups (e.g., parent teacher organizations and Title I) to provide information related to child development and/or parenting skills.

3. Formal strategies are in place to include parents/guardians in the educational process.

REVISED PUBLIC COST: The cost of this proposed rule to public school districts is an estimated cost of $1,848,876,751 for salaries based on the recommended standards for staff assignment for FY 2015 for the life of the rule based on the current cost.

REVISED FISCAL NOTE
PUBLIC COST

I. RULE NUMBER

Title: Department of Elementary and Secondary Education

Division: Division of Learning Services - 20

Chapter: Office of Quality Schools - 100

Type of Rulemaking: Proposed Rule

Rule Number and Name: 5 CSR 20-100.255 Missouri School Improvement Program–5 Resource and Process Standards and Indicators

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Public Elementary and Secondary School Districts	$1,848,876,751 is an estimated cost for salaries based on the recommended standards for staff assignment for FY2015 for the life of the rule based on the current costs.

III. WORKSHEET

Cost for Public Elementary and Secondary Districts
Based upon these standards, district resource needs will vary based upon on student enrollment. Other factors include the size of individual school buildings and the number of staff employed. For purposes of this fiscal note, the calculation of the total cost for all school districts is based on the number of buildings that correspond to the enrollment or staff sizes indicated in the standard.

	4th Cycle	MSIP-5	Change	Notes
Class Size and Assigned Enrollment	$1,412,117,358	$1,412,117,358	$0	
Library Media Staff	$ 75,255,383	$ 75,255,383	$0	
Guidance/Counseling Staff	$ 75,510,086	$ 75,510,086	$0	
Associates/Asst. Supt.	$ 34,228,500	$ 34,228,500	$0	
Principals/Bldg. Admin.	$ 178,517,183	$ 251,765,424 $1,848,876,751	+$73,248,241	This change reflects a change in the principal student ratio from 4th Cycle MSIP to MSIP-5. 4th Cycle reflects a 1/500 principal/student ratio. MSIP-5 reflects a 1/400 principal/student ratio.

IV. ASSUMPTIONS

This rule establishes Resource and Process Standards and Indicators for the Missouri School Improvement Program-5 (MSIP-5), designed to promote continuous improvement in districts on a statewide basis. Classification of local school districts will be determined by the MSIP-5 Performance Standards and Indicators.
Under current state law, districts are not held accountable to the resource standards during the FY2011, FY2012 and FY2013 if the state aid foundation formula is underfunded. If the Governor withholds funds from the state aid formula during the current year, districts would not be held accountable for the resource standards during the 2013-14 school year.

Data for both 4th Cycle MSIP and MSIP-5 are based on the most recently completed school year.

Class Size and Assigned Enrollment:

K-2 208,108 students/25 students per class = 8,324 teachers
8,324 teachers x $46,731 Average Teachers Salary = $388,988,844

3-4 134,685 students/27 students per class = 4,988 teachers
4,988 teachers x $46,731 Average Teachers Salary = $233,094,228

5-6 136,581 students/30 students per class = 4,553 teachers
4,553 teachers x $46,731 Average Teachers Salary = $212,766,243

9-12 407,654 students/33 students per class = 12,353 teachers
12,353 teachers x $46,731 Average Teachers Salary = $577,268,043

Library Media Staff

1,439 Library Media Staff x $52,297 Average = $75,255,383

Guidance and Counseling Staff

1,439 Guidance and Counseling Staff x $52,474 Average Salary = $75,510,086

Associates/Assistants to the Superintendent

300 Associates/Assistants to the Superintendent x $114,095 Average Salary = $34,228,500

Principals/Building Administrators

3,084 Principals/Bldg. Administrators x $81,636 Average Salary = $251,765,424
(MSIP-5)

2,186.75 Principals/Bldg. Administrators x $81,636 Average Salary = $178,517,523
(4th Cycle MSIP)

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 200—Office of College and Career Readiness

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 161.092 and 178.530, RSMo Supp. 2012, the board adopts a rule as follows:

5 CSR 20-200.280 Private School Agriculture Programs **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1766–1768). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The State Board of Education (board) received four (4) comments on the proposed rule.

COMMENT #1: Schellie Blochberger, parent of private school student, is pleased at the possibility of having an agricultural education program in place for private schools as this can only be a positive for everyone involved. This is a positive and major step for both private schools and the state of Missouri in their commitment to education and the agricultural industry.
RESPONSE: The board reviewed the comment and determined no change is needed.

COMMENT #2: Lisa H. Walker commented that agricultural programs are very important and would like to see private schools have the same opportunities as public schools to be involved in this program and Future Farmers of America (FFA).
RESPONSE: The board reviewed the comment and determined no change is needed.

COMMENT #3: Ryan Going asked that his email be accepted as an account of full support of allowing the private school sector to be a part of all FFA programs.
RESPONSE: The board reviewed the comment and determined no change is needed.

COMMENT #4: John Engelbrecht, Executive Director for Calvary Lutheran High School, wrote in strong support of this rule. With the implementation of this rule, Agricultural Programs would be available to students in nonpublic schools. Agriculture is a very important aspect of the state of Missouri and this broadens the student base for these programs. Everyone in education wants what is best for young people and this rule opens up doors for more young people to be exposed to and learn quality life skills. He is very excited to have the opportunity to build Ag Science into the Curriculum.
RESPONSE: The board reviewed the comment and determined no change is needed.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 300—Office of Special Education

ORDER OF RULEMAKING

By the authority vested in the State Board of Education under section 161.092, RSMo Supp. 2012, and section 162.685, RSMo 2000, the board hereby amends a rule as follows:

5 CSR 20-300.110 is amended.

A notice of proposed rulemaking was not published because state program plans required under federal education acts or regulations are specifically exempt under section 536.021, RSMo. During the month of August 2012, the Office of Special Education conducted two (2) public hearing webinars regarding proposed changes to the Part B State Plan implementing the Individuals with Disabilities Education Act (IDEA).

This rule becomes effective thirty (30) days after publication in the *Code of State Regulations*. This rule describes Missouri's services for children with disabilities, in accordance with Part B of the Individuals with Disabilities Education Act (IDEA).

5 CSR 20-300.110 Individuals with Disabilities Education Act, Part B. This order of rulemaking amends section (2) and amends the incorporated by reference material, *Regulations Implementing Part B of the Individuals with Disabilities Education Act*, to bring the program plan in compliance with federal statutes.

(2) The content of this state plan for the Individuals with Disabilities Education Act (IDEA), Part B, which is hereby incorporated by reference and made a part of this rule, meets the federal statute and Missouri's compliance in the following areas. A copy of the IDEA, Part B (revised January 2013) is published by and can be obtained from the Department of Elementary and Secondary Education, Office of Special Education, 205 Jefferson Street, PO Box 480, Jefferson City, MO 65102-0480. This rule does not incorporate any subsequent amendments or additions.

(F) Department Responsibilities:
1. General Supervision Responsibilities;
2. Application, Evaluation, and Approval of Private Educational Agencies;
3. Child Complaint Process;
4. Full Educational Opportunities Goal;
5. Methods of Ensuring Services;
6. Performance Goals and Indicators;
7. Public Participation;
8. Public Attention;
9. State Advisory Panel;
10. Suspension and Expulsion Rates;
11. Access to Instructional Materials;
12. Overidentification and Disproportionality;
13. Prohibition on Mandatory Medication;
14. State Administration;
15. Personnel Qualifications; and
16. Personnel Standards Chart.

(G) Local Educational Agency (LEA) Eligibility:
1. General Requirements;
2. Fiscal Requirements; and
3. Compliance Requirements.

AUTHORITY: section 161.092, RSMo Supp. 2012, and section 162.685, RSMo 2000. This rule previously filed as 5 CSR 70-742.140. Original rule filed April 11, 1975, effective April 21, 1975. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed March 1, 2013, effective May 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 300—Office of Special Education

ORDER OF RULEMAKING

By the authority vested in the State Board of Education under sections 160.900–160.925 and 161.092, RSMo Supp. 2012, the board hereby amends a rule as follows:

5 CSR 20-300.120 is amended.

A notice of proposed rulemaking was not published because state program plans required under federal education acts or regulations are specifically exempt under section 536.021, RSMo. Public hearings were not held because the Office of Special Education Programs (OSEP) required the change and did not require public hearings be held.

This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*. This rule describes Missouri's services for infants and toddlers with disabilities, in accordance with Part C of the Individuals with Disabilities Education Act (IDEA), Public Law 105-17.

5 CSR 20-300.120 Individuals with Disabilities Education Act, Part C. This order of rulemaking makes changes to sections (2) and (5) and amends the incorporated by reference material, *Regulations Implementing Part C of the Individuals with Disabilities Education Act First Steps Program*.

(2) The Missouri state plan for the regulations implementing Part C of the Individuals with Disabilities Education Act (IDEA) First Steps Program contains the administrative provisions for the delivery of the state's federally assisted early intervention system. The Missouri state plan for the IDEA, Part C is hereby incorporated by reference and made a part of this rule. A copy of the IDEA, Part C (revised January 2013) is published by and can be obtained from the Department of Elementary and Secondary Education, Special Education Compliance Section, 205 Jefferson Street, PO Box 480, Jefferson City, MO 65102-0480. This rule does not incorporate any subsequent amendments or additions.

(5) The content of this state plan, as submitted to the United States Department of Education, meets the federal statute and Missouri's compliance in the following areas:
(A) Definitions;
(B) Lead Agency;
(C) Public Participation;
(D) Central Directory;
(E) Public Awareness;
(F) State Interagency Coordinating Council;
(G) Child Find;
(H) Traditionally Underserved Groups;
(I) Referral Procedures;
(J) Eligibility Criteria;
(K) Evaluation and Assessment Procedures;
(L) Individualized Family Service Plan;
(M) Transition to Preschool and Other Programs;
(N) Comprehensive System of Personnel Development;
(O) Personnel Standards;
(P) Parental Rights;
(Q) Fiscal Administration;
(R) System of Payments;
(S) Supervision and Monitoring of Programs;
(T) Policies for Contracting or Otherwise Arranging for Services; and
(U) Data Collection and Annual Reports.

AUTHORITY: sections 160.900–160.925, 161.092, and 376.1218, RSMo Supp. 2012. This rule previously filed as 5 CSR 70-742.141. Executive Order 94-22 of the Governor, Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq. Original rule filed Dec. 29, 1997, effective March 30, 1998. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed March 1, 2013, effective May 30, 2013.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 400—Office of Educator Quality

ORDER OF RULEMAKING

By the authority vested in the State Board of Education under sections 161.092, 168.021, 168.071, 168.081, and 168.400, RSMo Supp. 2012, and sections 168.011, 168.405, and 168.409, RSMo 2000, the board amends a rule as follows:

5 CSR 20-400.280 Required Assessments for Professional Education Certification in Missouri **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2012 (37 MoReg 1643–1646). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2220—State Board of Pharmacy
Chapter 6—Pharmaceutical Care Standards

ORDER OF RULEMAKING

By the authority vested in the State Board of Pharmacy under section 338.280, RSMo 2000, and sections 338.140 and 338.400, RSMo Supp. 2012, the board adopts a rule as follows:

20 CSR 2220-6.100 Pharmacy Standards for Dispensing Blood-Clotting Products **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 17, 2012 (37 MoReg 2286–2291). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care

Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.010 Definitions **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1774–1778). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-2.020 General Membership Provisions **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1778). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-2.020 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1778–1789). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received six (6) comments on the proposed rule.

COMMENT #1: MCHCP staff commented that, under section (2), clarification is needed regarding when coverage ends if a covered dependent loses his/her eligibility.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (2)(G)3. that coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

COMMENT #2: MCHCP staff commented that, under section (3), clarification is needed regarding what happens to a subscriber's dental and/or vision coverage when subscribers do not take action during open enrollment.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subsections (3)(A), (3)(B), (3)(C), (3)(D), and (3)(E) that subscribers enrolled in dental and/or vision coverage who do not complete open enrollment will be enrolled in the same level of coverage in the same plan(s), effective the first day of the next calendar year.

COMMENT #3: MCHCP staff commented that, under section (4), clarification is needed regarding when a new employee and his/her dependents' coverage begins.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (4)(A)1. that a new employee and his/her dependents' coverage begins on the first day of the month after enrollment in SEBES.

COMMENT #4: MCHCP staff commented that, under section (7), clarification is needed regarding when coverage ends due to a divorce.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subparagraph (7)(A)4.A., that coverage ends on the last day of the month in which the divorce decree and completed form are received by MCHCP or MCHCP otherwise receives credible evidence of a final divorce that results in loss of eligibility under the plan.

COMMENT #5: MCHCP staff commented that, under section (8), clarification is needed regarding the circumstances in which a subscriber may cancel coverage.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subsection (8)(C) that a subscriber cannot cancel medical coverage on his/her spouse or children during divorce or legal separation proceedings unless the subscriber submits a notarized letter from the spouse stating s/he is agreeable with the termination.

COMMENT #6: MCHCP staff commented that, under section (10), clarification is needed regarding when a subscriber must notify MCHCP of a change in status to be eligible for COBRA.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (10)(C)1. that the subscriber or applicable member must notify MCHCP within sixty (60) days of a change in status to be eligible for COBRA coverage.

22 CSR 10-2.020 General Membership Provisions

(2) Eligibility Requirements.
(G) Dependent Coverage. Eligible dependents include:
1. Spouse.
A. State employees eligible for coverage under the Missouri Department of Transportation, Department of Conservation, or the Highway Patrol medical plans may not enroll as a spouse under MCHCP.
B. Active Employee Coverage of a Spouse.
(I) If both spouses are active state employees covered by MCHCP, each spouse must enroll separately.
C. Retiree Coverage of a Spouse.
(I) A state retiree may enroll as a spouse under an employee's coverage or elect coverage as a retiree.
(II) At retirement, an employee eligible for coverage under the Missouri Department of Transportation, Department of Conservation, or the Highway Patrol medical plans may enroll as a

spouse under MCHCP;

2. Children.

A. Children may be covered through the end of the month in which they turn twenty-six (26) years old if they meet one (1) of the following criteria:

(I) Natural child of subscriber or spouse;

(II) Legally-adopted child of subscriber or spouse;

(III) Child legally placed for adoption of subscriber or spouse;

(IV) Stepchild of subscriber. Such child will continue to be considered a dependent after the stepchild relationship ends due to the death of the child's natural parent and subscriber's spouse;

(V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent child after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

(VI) Grandchild for whom the covered subscriber or covered spouse has legal guardianship or legal custody;

(VII) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years old if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years old;

(VIII) Newborn of a dependent so long as the parent continues to be covered as a dependent of the subscriber;

(IX) Child for whom the subscriber or covered spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or

(X) A child under twenty-six (26) years, who is a state employee, may be covered as a dependent of a state employee.

B. A child who is twenty-six (26) years old or older and is permanently disabled in accordance with subsection (5)(G), may be covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

C. A child may only be covered by one (1) parent if his/her parents are married to each other and are both covered under an MCHCP medical plan.

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. The claims administrator will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time; or

3. Changes in dependent status. If a covered dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days of the loss of eligibility. Coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(3) Enrollment Procedures.

(A) Active Employee Coverage.

1. Statewide Employee Benefit Enrollment System (SEBES). A new employee must enroll or waive coverage through SEBES at www.sebes.mo.gov within thirty-one (31) days of his/her hire date. If enrolling dependents, proof of eligibility must be submitted as defined in section (5).

2. An active employee may elect coverage and/or change coverage levels during the annual open enrollment period.

3. An active employee may apply for coverage for himself/herself and/or for his/her dependents if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. An employee and his/her dependents may enroll within sixty (60) days if s/he involuntarily loses employer-sponsored coverage under one (1) of the following circumstances:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends; or

C. If an active employee or his/her dependent loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

D. If an active employee or active employee's spouse receives a court order stating s/he is responsible for covering a dependent, the active employee may enroll the dependent in an MCHCP plan within sixty (60) days of the court order.

4. If an employee is currently enrolled in medical coverage and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the employee is currently enrolled in, effective the first day of the next calendar year.

5. If an employee is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

6. If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains errors, MCHCP will notify the employee of such by mail, phone, or secure message. The employee must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(B) Retiree Coverage.

1. To enroll or continue coverage at retirement, the employee and his/her dependents must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date. Coverage is effective on retirement date; or

B. A completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last two (2) payrolls and the option to pre-pay premiums through the cafeteria plan; or

C. A completed enrollment form within thirty-one (31) days with proof of prior medical coverage under a group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he and his/her dependents choose to enroll in an MCHCP plan at retirement and have had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A retiree may

enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. If coverage was not maintained while on disability, the employee and his/her dependents may enroll within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. If a retiree is currently enrolled in medical coverage and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the PPO 600 plan provided through the vendor the retiree is currently enrolled in, effective the first day of the next calendar year.

6. If a retiree is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

7. If a retiree submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Retiree Enrollment form that is incomplete or contains errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(C) Terminated Vested Coverage.

1. A terminated vested subscriber may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a terminated vested subscriber is currently enrolled in medical coverage and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 plan provided through the vendor the terminated vested subscriber is currently enrolled in, effective the first day of the next calendar year.

4. If a terminated vested subscriber is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

5. If a terminated vested subscriber submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Terminated Vested Enrollment form that is incomplete or contains errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a long-term disability subscriber is currently enrolled in medical coverage and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 plan provided through the vendor the long-term disability subscriber is currently enrolled in, effective the first day of the next calendar year.

4. If a long-term disability subscriber is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

5. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(E) Survivor Coverage.

1. A survivor must submit a survivor enrollment form and a copy of the death certificate within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the dependent must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible dependent(s) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of

thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. A survivor may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

4. If a survivor is currently enrolled in medical coverage and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the PPO 600 plan provided through the vendor the survivor is currently enrolled in, effective the first day of the next calendar year.

5. If a survivor is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

6. If a survivor submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Survivor Enrollment form that is incomplete or contains errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(4) Effective Date Provision. In no circumstances can the effective date be before the eligibility date. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

(A) Employee and Dependent Effective Dates.

1. A new employee and his/her dependents' coverage begins on the first day of the month after enrollment through SEBES. Except at initial employment, an employee and his/her eligible dependents' effective date of coverage is the first of the month coinciding with or after the eligibility date. Except for newborns, the effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP.

2. The effective date of coverage for a life event shall be as follows:

A. Marriage.

(I) If a subscriber enrolls and/or enrolls his/her spouse before a wedding date, coverage becomes effective on the wedding date subject to receipt of proof of eligibility. The monthly premium is not prorated.

(II) If an active employee enrolls within thirty-one (31) days of a wedding date, coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form and proof of eligibility;

B. Newborn.

(I) If a subscriber or employee enrolls his/her newborn or a subscriber enrolls a newborn of his/her dependent within thirty-one (31) days of birth date, coverage becomes effective on the newborn's birth date.

(II) If a subscriber does not elect to enroll a newborn of a dependent within thirty-one (31) days of birth, s/he cannot enroll the dependent of a dependent at a later date;

C. Adoption or placement for adoption.

(I) If a subscriber or employee enrolls an adopted child within thirty-one (31) days of adoption or placement of a child, coverage becomes effective on the date of adoption or placement for adoption;

D. Legal guardianship and legal custody.

(I) If a subscriber or employee enrolls a dependent due to legal guardianship or legal custody within thirty-one (31) days of guardianship or custody effective date, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

E. Foster care.

(I) If a subscriber or employee enrolls a foster child due to placement in the subscriber or employee's care within thirty-one (31) days of placement, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day; or

F. Employee.

(I) If an employee enrolls due to a life event, the effective date for the employee is the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day.

3. An employee and his/her eligible dependent(s) who elect coverage and/or change coverage levels during open enrollment shall have an effective date of January 1 of the following year.

4. An employee who terminates all employment with the state (not simply moves from one (1) agency to another) and is rehired as a new state employee before the participation in MCHCP coverage terminates, and his/her eligible dependent(s) who were covered by the plan, will have continuous coverage.

A. The employee cannot increase his/her level of coverage or change plans.

B. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January unless s/he is eligible due to a life event.

5. An employee who terminates all employment with the state and is rehired in the following month and his/her eligible dependent(s) who were covered by the plan may choose to have continuous coverage or coverage the first of the month after his/her hire date if an enrollment form is submitted within thirty-one (31) days of hire date.

A. If the employee's coverage is continuous, s/he cannot increase his/her level of coverage or change plans.

B. If the employee requests coverage to begin the first of the month after his/her hire date, s/he can make changes to his/her coverage.

C. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January 1 unless s/he is eligible due to a life event.

6. An employee who transfers in the same month from a state agency with MCHCP benefits to another agency with MCHCP benefits, and his/her eligible dependent(s) who were covered, will have continuous coverage. The employee must inform the former agency of the transfer in lieu of a termination. The employee will be transferred through eMCHCP by the former state agency's human resource or payroll representative to the new state agency.

A. The employee cannot increase his/her level of coverage or change plans.

B. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January 1 unless s/he is eligible due to a life event.

7. An employee who transfers state employment from the Missouri Department of Transportation (MoDOT), Missouri State Highway Patrol, or the Department of Conservation and his/her dependents to another agency with MCHCP benefits will maintain his/her dental and/or vision coverage and may enroll in medical coverage within thirty-one (31) days of transfer. If enrollment is made within thirty-one (31) days of transfer, MCHCP medical coverage is effective with no break in coverage. Dental and vision coverage is continuous throughout the calendar year. An employee cannot enroll in

dental and vision at the time of transfer if s/he was not enrolled prior to the transfer.

A. If an employee waives coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January unless s/he is eligible due to a life event.

8. A state employee who has medical coverage under MCHCP and transfers state employment to MoDOT, Missouri State Highway Patrol, or the Department of Conservation and his/her dependents are no longer eligible for MCHCP coverage. MCHCP medical coverage is terminated the last day of the month of the employee's termination.

9. Coverage is effective for a dependent child the first of the month coinciding with or after the Qualified Medical Child Support Order is received by the plan or date specified by the court.

(7) Termination.

(A) Unless stated otherwise, termination of coverage shall occur on the last day of the calendar month coinciding with or after any of the following events, whichever occurs first:

1. Failure to make any required contribution toward the cost of coverage. If MCHCP has not received payment of premium at the end of the thirty-one- (31-) day grace period, the subscriber will be retroactively terminated to the date covered by his/her last paid premium. The subscriber will be responsible for the value of services rendered after the retroactive termination date, including, but not limited to, the grace period;

2. Entry into the armed forces of any country;

3. With respect to active employee(s) and his/her dependents, termination of employment in a position covered by the MCHCP, except as expressly specified otherwise in this rule;

4. With respect to dependents, upon divorce or legal separation from the subscriber, when a child reaches age twenty-six (26), or when a dependent is no longer eligible for coverage. A subscriber must terminate coverage for his/her spouse and stepchild(ren) at the time his/her divorce is final.

A. When a subscriber drops dependent coverage after a divorce, s/he must submit a completed form, a copy of the divorce decree, and current addresses of all affected dependents. Coverage ends on the last day of the month in which the divorce decree and completed form are received by MCHCP or MCHCP otherwise receives credible evidence of a final divorce that results in loss of member eligibility under the plan;

5. Death of dependent. The dependent's coverage ends on the date of death. The subscriber must submit completed form and a copy of the death certificate within thirty-one (31) days of death;

6. A member's act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact; or

7. A member's threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP.

(8) Voluntary Cancellation of Coverage.

(C) A subscriber cannot cancel medical coverage on his/her spouse or children during a divorce or legal separation proceedings unless s/he submits a notarized letter from his/her spouse stating s/he is agreeable to termination of coverage pending divorce. If premiums are collected pre-tax through the Missouri State Employees' Cafeteria Plan (MoCafe), medical coverage can only be cancelled at the time of divorce.

(10) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(C) Required Notifications.

1. To be eligible for COBRA, the subscriber or applicable member must notify MCHCP of a divorce, legal separation, a child turning age twenty-six (26), or Medicare entitlement within sixty (60) days of the event date.

2. The human resource/payroll office of the subscriber must notify MCHCP of an employee's death, termination, or reduction of hours of employment.

3. If a COBRA member is disabled within the first sixty (60) days of COBRA coverage and the disability continues for the rest of the initial eighteen- (18-) month period of continuing coverage, the member must notify MCHCP that s/he wants to continue coverage within sixty (60) days, starting from the latest of: 1) the date on which the SSA issues the disability determination; 2) the date on which the qualifying event occurs; or 3) the date on which the member receives the COBRA general notice. The member must also notify MCHCP within thirty-one (31) days of any final determination that the individual is no longer disabled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.030 Contributions **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1790–1793). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.045 Plan Utilization Review Policy **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1794–1795). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1795). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1795–1796). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. 2012, the director amends a rule as follows:

22 CSR 10-2.053 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1796–1799). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received three (3) comments on the proposed amendment.

COMMENT #1: Steven Robino, on behalf of Coventry Health Care of Kansas, Inc., commented that Coventry was concerned with the use of Usual, Customary and Reasonable, as many insurers have moved away from using Usual, Customary and Reasonable due to increased litigation. He also commented that the requirement that payment for non-network medical claims to be processed at the eighty-fifth percentile of Usual, Customary and Reasonable would risk degradation of network discounts and the adequacy of contracted providers over time.
RESPONSE: After an analysis of this issue, MCHCP has determined no change is needed at this time as a result of this comment.

COMMENT #2: MCHCP staff commented that, under section (9), clarification is needed on who can enroll in the high deductible health plan in the upcoming year.
RESPONSE: After an analysis of this issue, MCHCP has determined no change is needed at this time as a result of this comment.

COMMENT #3: MCHCP staff commented that, under section (12), clarification is needed when new employees and subscribers electing coverage due to a life event or loss of employer-sponsored coverage may change plan selections after selecting the high deductible health plan.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subsection (12)(C) that a subscriber will not be able to voluntarily change his/her plan selection after the bi-annual contribution has been deposited into the subscriber's Health Savings Account (HSA).

22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges

(12) Health Savings Account (HSA) Contributions.

(C) A new employee or subscriber electing coverage due to a life event or loss of employer-sponsored coverage with an effective date after the MCHCP bi-annual contributions will receive a prorated bi-annual contribution. A subscriber will not be able to voluntarily change his/her plan selection after the bi-annual contribution has been deposited into the subscriber's HSA.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1800). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.055 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1800–1807). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that, under subsection (4)(F), clarification is needed for the benefit for treatment received by a non-network provider in the network hospital or facility.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subparagraph (4)(F)25.H., that if a member received treatment in a network hospital or facility by a non-network provider, services are paid at the network benefit.

COMMENT #2: Steven Robino, on behalf of Coventry Health Care of Kansas, Inc., commented that the new section outlining disease management benefits should not list the specific medical conditions for which a disease management program may exist because disease management programs should be flexible to account for changes of disease states within the covered population and/or changes within standards of care or therapies. He also commented that Coventry does offer disease management programs for each program except for hypertension, which is only offered as a component of other programs, such as coronary artery disease, congestive heart failure, and chronic obstructed pulmonary disease.
RESPONSE AND EXPLANATION OF CHANGE: Based on Mr. Robino's comment, a separate disease management subsection was added under section (3) to clarify the differences in UMR and Coventry's disease management programs.

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges

(3) Disease Management.

(A) A non-Medicare subscriber and his/her eligible non-Medicare dependents enrolled in an UMR plan may participate in a disease management program if s/he has one (1) of the following chronic conditions:

1. Coronary artery disease;
2. Diabetes (includes children);
3. Asthma (includes children);
4. Congestive heart failure;
5. Chronic obstructive pulmonary disease;
6. Hypertension; or
7. Depression with one (1) other disease management condition.

(B) A non-Medicare subscriber and his/her eligible non-Medicare dependents enrolled in a Coventry plan may participate in a disease management program if s/he has one (1) of the following chronic conditions:

1. Coronary artery disease;
2. Diabetes (includes children);
3. Asthma (includes children);
4. Congestive heart failure;
5. Chronic obstructive pulmonary disease;
6. Hypertension with one (1) other disease management condition; or
7. Depression with one (1) other disease management condition.

(C) A member identified as eligible for disease management through medical and prescription drug claims will receive an invitation to participate.

(4) Covered Charges Applicable to the PPO 300 Plan, PPO 600 Plan, and HDHP.

(F) Plan benefits for the PPO 300 Plan, PPO 600 Plan, and HDHP are as follows:

1. Allergy testing and immunotherapy. Allergy testing and allergy immunotherapy is covered for members with clinically-significant allergic symptoms. No coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning;

2. Ambulance service. Ambulance transport services involve the use of specially-designed and equipped vehicles to transport ill or injured individuals. Ambulance transportation by ground to the nearest appropriate facility is covered when other means of transportation would be contraindicated. This can include emergent and non-emergent, yet medically necessary situations. Ambulance transportation by air to the nearest appropriate facility is covered only if the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Use of air ambulance or medical helicopter service from any country returning to the U.S. is excluded;

3. Applied behavior analysis for autism. For children younger than age nineteen (19), the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior are covered with a forty-one thousand two hundred sixty-three dollar ($41,263) annual limit. The annual limit may be exceeded, upon prior authorization by the medical plan, if services beyond the annual limit continue to be medically necessary;

4. Bariatric surgery. When specific criteria for bariatric surgery have been met, any of the following open or laparoscopic bariatric surgery procedures are covered when performed at a Centers of Excellence Facility for Bariatric Surgery as determined by the Centers for Medicare and Medicaid Services:

A. Roux-en-Y gastric bypass;

B. Sleeve gastrectomy;

C. Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

D. Adjustable silicone gastric banding. Adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure are covered;

E. Surgical reversal of bariatric surgery is covered when complications of the original surgery (such as stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink or cause vomiting of prescribed meals; or

F. Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss is covered when specific criteria are met. Inadequate weight loss due to individual noncompliance with post-operative nutrition and exercise recommendations is not a medically necessary indication for revision or conversion surgery and is not covered;

5. Birth control devices and injections. Birth control is any method used to prevent pregnancy. Food and Drug Administration-(FDA-) approved birth control devices and injections are covered when administered in a physician's office;

6. Blood storage. Storage of whole blood, blood plasma, and blood products is only covered in conjunction with medical treatment that requires immediate blood transfusion support;

7. Cancer trials. Coverage for routine patient care costs incurred as the result of a Phase II, III, or IV clinical trial that is approved by an appropriate entity and is undertaken for the purposes of the prevention, early detection, or treatment of cancer. Coverage includes

routine patient care costs incurred for drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's condition. Coverage includes reasonable services needed to administer the drug or use the device under evaluation in the clinical trial;

8. Cardiac rehabilitation. Coverage for an electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) when it is individually prescribed by a physician and a formal exercise stress test is completed following the event and prior to the initiation of the program. Up to thirty-six (36) visits are covered within a twelve-(12-) week period per incident without prior authorization. Any visits after the first thirty-six (36) within a twelve- (12-) week period per incident may be covered, upon prior authorization by the medical plan, if services continue to be medically necessary;

9. Chelation therapy. Chelation therapy agents covered for FDA-approved indication(s) and associated condition(s). Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit are explicitly excluded under MCHCP's benefit plan. Therefore, treatment of metal toxicity that occurs as a result of occupational exposure is not covered;

10. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered. Up to twenty-six (26) visits covered annually. Any visits after the first twenty-six (26) may be covered, upon prior authorization by the medical plan, if services continue to be medically necessary;

11. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation is covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device.

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

12. Dental care/accidental injury. Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors, or cysts. Oral surgery includes but is not limited to reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization. General anesthesia is covered when dental care is provided in a participating or non-participating hospital or surgical center;

13. Durable medical equipment (DME)/medically-necessary disposable supplies. DME is covered when the equipment is ordered by a physician to treat an injury or illness. DME includes, but is not limited to, insulin pumps, oxygen, augmentative communication devices, and manual and powered mobility devices. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, colostomy and ureterostomy bags and prescription compression stockings, are covered. Prescription compression stockings are limited to two (2) pairs or four (4) individual stockings per plan year. Non-reusable disposable supplies, including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered. Repair and replacement of DME is covered when—

A. Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

B. Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

C. The physician provides documentation that the condition of the member changes or if growth-related;

14. Emergency room services. An emergency medical condition is defined as the manifestation of acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If a member is admitted to hospital, s/he may be required to transfer to network facility for maximum benefit;

15. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

16. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when associated with systemic conditions that are significant enough to result in severe circulatory insufficiency and/or areas of desensitization in the lower extremities and service is provided by a qualified health provider. Foot care is considered routine in nature and not covered in the absence of systemic disease that has resulted in severe circulatory insufficiency and/or areas of desensitization in the lower extremities;

17. Genetic counseling. The National Society of Genetic Counselors defines genetic counseling as: "The process of helping people understand and adapt to the medical, psychological, and familial implications of genetic contributions to disease." Pre-test and post-test genetic counseling with a physician or a licensed or certified genetic counselor covered for an individual recommended for covered heritable genetic testing;

18. Genetic testing. No coverage for testing based on family history alone. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

A. The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

B. The result of the test will directly impact the treatment being delivered to the member;

C. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

D. After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

19. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

20. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

21. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars ($1,000).

B. Programmable: two thousand dollars ($2,000).

C. Digital: two thousand five hundred dollars ($2,500).

D. Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

22. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by physician;

23. Home health care. Skilled home health care is covered for members who are homebound because of illness or injury (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care); services must be performed by a registered nurse or licensed practical (vocational) nurse, licensed therapist, or a registered dietitian;

24. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week;

25. Hospital (includes inpatient, outpatient, and surgical centers). The following benefits are covered:

A. Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

B. Intensive care unit room and board;

C. Surgery, therapies, and ancillary services—

(I) Cornea transplant-travel and lodging are not covered for cornea transplant;

(II) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(III) Sterilization for the purpose of birth control is covered;

(IV) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(V) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19); and

(VI) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

D. Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(I) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(II) The member's mental health disorder must be treatable in an inpatient facility;

(III) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association *Diagnostic and Statistical Manual* (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region; and

(IV) The attending physician must be a psychiatrist. If the admitting physician is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board eligible or board certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending physician must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

E. Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment;

F. Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country;

G. Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(I) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(II) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(III) A state-licensed psychologist;

(IV) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(V) Licensed professional counselor; and

H. Treatment in a network hospital or facility by a non-network provider. Treatment received in a network hospital or facility by a non-network provider is covered at the network benefit.

26. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. See birth control devices and injections for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;
(II) Crohn's disease;
(III) Ulcerative colitis;
(IV) Inflammatory bowel disease;
(V) Intestinal malabsorption;
(VI) Fish tapeworm anemia;
(VII) Vitamin B12 deficiency;
(VIII) Other vitamin B12 deficiency anemia;
(IX) Macrocytic anemia;
(X) Other specified megaloblastic anemias;
(XI) Megaloblastic anemia;
(XII) Malnutrition or alcoholism;
(XIII) Thrombocytopenia, unspecified;
(XIV) Dementia in conditions classified elsewhere;
(XV) Polyneuropathy in diseases classified elsewhere;
(XVI) Alcoholic polyneuropathy;
(XVII) Regional enteritis of small intestine;
(XVIII) Postgastric surgery syndromes;
(XIX) Other prophylactic chemotherapy;
(XX) Intestinal bypass or anastamosis status; and
(XXI) Acquired absence of stomach;

27. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition;

28. Maternity coverage. Prenatal and postnatal care is covered. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility;

29. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program. Counseling must be ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian) for up to three (3) sessions annually with a registered dietitian without prior authorization. Any sessions after the three (3) may be covered upon prior authorization by the medical plan, if services continue to be medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program. Conditions for which nutritional evaluation and counseling are not covered include, but are not limited to, the following:

A. Attention-deficit/hyperactivity disorder (ADHD);

B. Chronic fatigue syndrome (CFS);

C. Idiopathic environmental intolerance (IEI); or

D. Asthma;

30. Nutritional therapy. Nutritional therapy is covered when it is—

A. The sole source of nutrition or a significant percentage of the daily caloric intake;

B. Used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

C. Prescribed by a physician;

D. Necessary to sustain life or health; and

E. Requires ongoing evaluation and management by a licensed healthcare provider;

31. Office visit. Member encounter with a health care or mental health care/chemical dependency provider in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan provided;

32. Orthognathic (jaw includes temporomandibular joint and prognathism) surgery is covered for the following specific conditions and when the conditions meet coverage criteria:

A. Acute traumatic injury and post-surgical sequela;

B. Cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequela;

C. Obstructive sleep apnea;

D. Cleft lip/palate (for cleft lip/palate related jaw surgery); and

E. Congenital anomalies. Examples of congenital anomalies include: midface hypoplasia, Pierre Robin Syndrome, Hemifacial Microsomia, and Treacher Collins Syndrome;

33. Orthotics. Therapeutic shoes, inserts, and/or modifications to therapeutic shoes; thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis; helmets—covered when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living; and cranial orthosis for plagiocephaly, cervical orthosis, hip orthosis, knee orthosis, and ankle-foot/knee-ankle-foot orthoses (AFO) are covered;

34. Physical, speech, and occupational therapy and rehabilitation services (outpatient). Up to sixty (60) combined visits allowed per incident. Any visits after the first sixty (60) may be covered upon prior authorization by the medical plan, if services continue to be medically necessary;

35. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Annual physical exams (well man, woman, and child) and routine lab and X-ray services ordered as part of the annual exam. One (1) exam per calendar year is covered. Additional visits as needed to obtain all necessary preventive services are covered for women depending on a woman's health status, health needs, and other risk factors. For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

F. Cancer screenings—

(I) Mammograms—one (1) exam per year, no age limit;

(II) Pap smears—one (1) per year, no age limit;

(III) Prostate—one (1) per year, no age limit; and

(IV) Colorectal screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Flu vaccination (influenza)—The seasonal flu vaccine is covered under the preventive care benefit. When shot is obtained out of network, member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive up to twenty-five dollars ($25). Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.

(I) Standard or preservative-free injectable influenza vaccine is a covered preventive service for members when influenza immunization is recommended by the member's doctor.

(II) Intradermal influenza vaccine is a covered preventive service for members eighteen (18) to sixty-four (64) years of age when influenza immunization is recommended by the member's doctor.

(III) Intranasally administered influenza vaccine is a covered alternative to injectable influenza vaccine for immunocompetent healthy persons two (2) to forty-nine (49) years of age when influenza immunization is recommended by the member's doctor;

36. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition, or if growth-related;

37. Pulmonary rehabilitation. Up to thirty-six (36) visits within a twelve- (12-) week period per incident. Any visits after the first thirty-six (36) within a twelve- (12-) week period per incident may be covered, upon prior authorization by the medical plan, if services continue to be medically necessary. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) and/or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis,

radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

38. Skilled nursing facility. Benefits are limited to one hundred twenty (120) days per calendar year;

39. Stimulators (for bone growth). Implantable bone growth stimulators covered as an outpatient surgery, nonimplantable bone growth stimulator covered under durable medical equipment.

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)). Medically-necessary DME to accelerate healing of fresh fractures, fusions, or delayed unions.

B. Electrical stimulation. Direct current electrical bone-growth stimulator medically necessary for delayed unions of fractures or failed arthrodesis, non-unions, failed fusions, and congenital pseudarthrosis and members who are at high risk for spinal fusion failure;

40. Transplants. When neither experimental nor investigational and medically necessary: stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered under the transplant benefits. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements. Travel, if approved, is limited to ten thousand dollars ($10,000) maximum per transplant.

A. Network. Includes travel and lodging allowance for recipient and his/her immediate family travel companion (younger than nineteen (19), both parents) if transplant facility is more than one hundred (100) miles from residence.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Transplant benefits at a non-network facility. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals not covered. Non-network facility charges and payments for transplants are limited to the following maximum only:

(I) Stem cell transplant—

(a) Allogeneic related—one hundred fifty-three thousand dollars ($153,000);

(b) Allogeneic unrelated—one hundred seventy-nine thousand dollars ($179,000); and

(c) Autologous stem cell transplant—one hundred five thousand dollars ($105,000);

(II) Heart—one hundred eighty-five thousand dollars ($185,000);

(III) Heart and lung—two hundred sixty-one thousand three hundred sixty-one dollars ($261,361);

(IV) Lung—one hundred forty-two thousand eight hundred seventeen dollars ($142,817);

(V) Kidney—eighty thousand dollars ($80,000);

(VI) Kidney and pancreas—one hundred thirty thousand dollars ($130,000);

(VII) Liver—one hundred seventy-five thousand nine hundred dollars ($175,900);

(VIII) Pancreas—ninety-five thousand dollars ($95,000); and

(IX) Small bowel—two hundred seventy-five thousand dollars ($275,000);

41. Urgent care. Services provided to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician's office but not severe enough to require treatment in a hospital emergency department; and

42. Vision. One (1) routine exam (including refractions) per covered person per calendar year.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. 2012, the director amends a rule as follows:

22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and HDHP Limitations **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1808–1809). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, and section 103.089, RSMo Supp. 2012, the director amends a rule as follows:

22 CSR 10-2.070 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1809). Those sections with changes are reprinted

here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT #1: MCHCP staff commented that under section (4), clarification is needed of Medicare's actual paid amount, not the Medicaid paid amount.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (4)(A)2., that the Medicare's actual paid amount is combined with the provider's Medicare contractual write off to determine what MCHCP considers the Medicare paid amount and not the Medicaid paid amount.

22 CSR 10-2.070 Coordination of Benefits

(4) Effect on the Benefits of MCHCP. This section applies, which in accordance with section (3), Order of Benefit Determination Rules, MCHCP is a secondary plan as to one (1) or more other plans.

(A) In the event that MCHCP is a secondary plan as to one (1) or more other plans, the benefits of MCHCP's PPO plans and High Deductible Health Plan may be reduced under this section so as not to duplicate the benefits of the other plan. The other plan's payment is subtracted from what MCHCP or its claims administrator would have paid in absence of this COB provision using the following criteria. If there is any balance, MCHCP or its claims administrator will pay the difference not to exceed what it would have paid in absence of this COB provision.

1. In the case where Medicare is primary for physician and outpatient facility claims, Medicare's allowed amount is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision.

2. In the case where Medicare is primary for inpatient facility claims, the amount the facility billed is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision. Medicare's actual paid amount is combined with the provider's Medicare contractual write off to determine what MCHCP considers the Medicare paid amount. Effective April 1, 2013, Medicare's allowed amount will be used as MCHCP's allowed amount for inpatient facility claims to determine what MCHCP would have paid in absence of this COB provision and the Medicare paid amount will no longer be combined with the provider's Medicare contractual write off.

3. In the case where another plan is primary, the lower allowed amount of either the primary plan or MCHCP is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.075 Review and Appeals Procedure **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1809–1812). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.080 Miscellaneous Provisions **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1812). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.090 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1812–1817). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that, under section (3), clarification is needed on which medical plans apply the reduced prescription drug copayments for Disease Management participation.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subsection (3)(A) that members enrolled in the Medicare Supplemental Plan are not eligible for the reduced non-formulary prescription copayment.

COMMENT #2: MCHCP staff commented that clarification is needed of when a member is considered actively participating in the Disease Management Program.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subsection (3)(B) that a member is considered actively participating in the Disease Management Program when s/he is enrolled in a Disease

Management Program through the medical plan vendor along with one (1) of the criteria for participation.

22 CSR 10-2.090 Pharmacy Benefit Summary

(3) Disease Management Program Reduced Non-Formulary Prescription Copayments—

(A) Members who are actively participating in the Disease Management Program and enrolled in the PPO 300 Plan or PPO 600 Plan are eligible for a reduced non-formulary prescription copayment as follows:

1. Fifty-five dollars ($55) for up to a thirty- (30-) day supply for a drug not on the formulary;

2. One hundred ten dollars ($110) for up to a sixty- (60-) day supply for a drug not on the formulary; and

3. One hundred thirty-seven dollars and fifty cents ($137.50) for up to a ninety- (90-) day supply for a drug not on the formulary; and

(B) A member is considered actively participating in the Disease Management Program when s/he is enrolled in a Disease Management Program through the medical plan vendor and one (1) of the following:

1. Is working one-on-one with a nurse; or

2. Has met his/her initial goals for condition control and receives up to two (2) calls per year from a nurse until the condition is managed independently; or

3. The medical plan vendor has determined the member does not require one-on-one work with a nurse.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-2.091 Wellness Program Coverage, Provisions, and Limitations **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1818). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. 2012, the director adopts a rule as follows:

22 CSR 10-2.130 Additional Plan Options **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1818–1819). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.010 Definitions **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1820–1823). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

22 CSR 10-3.020 General Membership Provisions **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1823). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-3.020 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1823–1832). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received six (6) comments on the proposed rule.

COMMENT #1: MCHCP staff commented that, under section (2), clarification is needed regarding when coverage ends if a covered dependent loses his/her eligibility.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (2)(G)3. that coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

COMMENT #2: MCHCP staff commented that, under section (3), clarification is needed when an employee is currently enrolled and does not complete an enrollment for the new calendar year, the employee and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subsections (3)(A), (3)(B), (3)(C), (3)(D), and (3)(E) that if a subscriber is currently enrolled and does not complete enrollment during the open enrollment period, the subscriber and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the subscriber and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity for the new year.

COMMENT #3: MCHCP staff commented that, under section (4), clarification is needed regarding when a new employee and his/her dependents coverage begins.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (4)(A)1. that a new employee and his/her eligible dependents or an employee rehired after his/her coverage terminates and his/her eligible dependent(s) are eligible to participate in the plan on the first day of the month following the employee's eligibility date as determined by the employer.

COMMENT #4: MCHCP staff commented that, under section (7), clarification is needed regarding when coverage ends due to a divorce.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subparagraph (7)(A)4.B. that coverage ends on the last day of the month in which the divorce decree and completed form are received by MCHCP or MCHCP otherwise receives credible evidence of a final divorce that results in loss of eligibility under the plan.

COMMENT #5: MCHCP staff commented that, under section (8), clarification is needed regarding the circumstances in which a subscriber may cancel coverage.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subsection (8)(C) that a subscriber cannot cancel medical coverage on his/her spouse or children during divorce or legal separation proceedings unless the subscriber submits a notarized letter from the spouse stating s/he is agreeable with the termination.

COMMENT #6: MCHCP staff commented that, under section (10), clarification is needed regarding when a subscriber must notify MCHCP of a change in status to be eligible for COBRA.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (10)(C)1. that the subscriber or applicable member must notify MCHCP within sixty (60) days of a change in status to be eligible for COBRA coverage.

22 CSR 10-3.020 General Membership Provisions

(2) Eligibility Requirements.

(G) Dependent Coverage. Eligible dependents include:

1. Spouse.

A. Active Employee Coverage of a Spouse.

(I) If both spouses have access to MCHCP benefits through two (2) different public entities, the employee and his/her spouse may elect to enroll in coverage separately through his/her respective employer or together through one (1) of the employers. The employee cannot have coverage through both public entities.

(II) If both spouses are employed by the same public entity with access to MCHCP benefits, the employee and spouse may elect coverage either as individuals or under the spouse (if allowed by the employer).

B. Retiree Coverage of a Spouse.

(I) A public entity retiree may enroll as a spouse under a public entity employee's coverage or elect coverage as a retiree;

2. Children.

A. Children may be covered through the end of the month in which they turn twenty-six (26) years old if they meet one (1) of the following criteria:

(I) Natural child of subscriber or spouse;

(II) Legally-adopted child of subscriber or spouse;

(III) Child legally placed for adoption of subscriber or spouse;

(IV) Stepchild of subscriber. Such child will continue to be considered a dependent after the stepchild relationship ends due to the death of the child's natural parent and subscriber's spouse;

(V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent child after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

(VI) Grandchild for whom the covered subscriber or covered spouse has legal guardianship or legal custody;

(VII) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years old if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years old;

(VIII) Newborn of a dependent so long as the parent continues to be covered as a dependent of the subscriber;

(IX) Child for whom the subscriber or covered spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or

(X) A child under twenty-six (26) years, who is eligible for MCHCP coverage as a subscriber, may be covered as a dependent of a public entity employee.

B. A child who is twenty-six (26) years old or older and is permanently disabled in accordance with subsection (5)(F), may be covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

C. A child may only be covered by one (1) parent if his/her parents are married to each other and are both covered under an MCHCP medical plan.

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once,

regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. The claims administrator will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time; or

3. Changes in dependent status. If a covered dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days of the loss of eligibility. Coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(3) Enrollment Procedures.

(A) Active Employee Coverage.

1.The public entity must enroll or waive coverage for a new employee by submitting a form signed by the employee and the payroll representative within thirty-one (31) days of his/her eligibility date. A new employee's coverage begins on the first day of the month after the hire date and the applicable waiting period.

2. An active employee may elect coverage and/or change coverage levels during the annual open enrollment period.

3. An active employee may apply for coverage for himself/herself and/or for his/her dependents if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. An employee and his/her dependents may enroll within sixty (60) days if s/he involuntarily loses employer-sponsored coverage under one (1) of the following circumstances:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends; or

C. If an active employee or his/her dependent loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

D. If an active employee or active employee's spouse receives a court order stating s/he is responsible for covering dependent, the active employee may enroll the dependent in an MCHCP plan within sixty (60) days of the court order; or

E. If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains errors, MCHCP will notify the public entity Human Resource Department of such by mail, phone, or secure message. The corrected form must be submitted to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

4. If an active employee is currently enrolled and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the employee and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(B) Retiree Coverage.

1. To enroll or continue coverage at retirement, the employee and his/her dependents must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date. Coverage is effective on retirement date; or

B. A completed enrollment form within thirty-one (31) days with proof of prior medical coverage under a separate group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he and his/her dependents choose to enroll in an MCHCP plan at retirement and have had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her dependent within sixty (60) days if the dependent involuntarily loses employer-sponsored coverage under one (1) of the following circumstances, and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. If coverage was not maintained while on disability, the employee and his/her dependents may enroll within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. If a retiree submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

6. If a retiree is currently enrolled and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the retiree and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(C) Terminated Vested Coverage.

1. A terminated vested subscriber may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled terminated vested subscriber may change from

one (1) medical plan to another during open enrollment but cannot add a dependent. If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a terminated vested subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

4. If a terminated vested subscriber is currently enrolled and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

4. If a long-term disability subscriber is currently enrolled and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(E) Survivor Coverage.

1. A survivor must submit a form and a copy of the death certificate within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the dependent must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible dependent(s) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. A survivor may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

4. If a survivor submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

5. If a survivor is currently enrolled and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the survivor and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(4) Effective Date Provision. In no circumstances can the effective date be before the eligibility date. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

(A) Employee and Dependent Effective Dates.

1. A new employee and his/her eligible dependents or an employee rehired after his/her coverage terminates and his/her eligible dependent(s) are eligible to participate in the plan on the first day of the month following the employee's eligibility date as determined by the employer. Except at initial employment, an employee and his/her eligible dependents' effective date of coverage is the first of the month coinciding with or after the eligibility date and after the waiting period. Except for newborns, the effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP.

2. The effective date of coverage for a life event shall be as follows:

A. Marriage.

(I) If a subscriber enrolls and/or enrolls his/her spouse before a wedding date, coverage becomes effective on the wedding date. The monthly premium is not prorated.

(II) If an active employee enrolls within thirty-one (31) days of a wedding date, coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form;

B. Newborn.

(I) If a subscriber or employee enrolls his/her newborn or a subscriber enrolls a newborn of his/her dependent within thirty-one (31) days of birth date, coverage becomes effective on the newborn's birth date.

(II) If a subscriber does not elect to enroll a newborn of a dependent within thirty-one (31) days of birth, s/he cannot enroll the dependent of a dependent at a later date;

C. Adoption or placement for adoption.

(I) If a subscriber or employee enrolls an adopted child within thirty-one (31) days of adoption or placement of a child, coverage becomes effective on the date of adoption or placement for adoption;

D. Legal guardianship and legal custody.

(I) If a subscriber or employee enrolls a dependent due to legal guardianship or legal custody within thirty-one (31) days of guardianship or custody effective date, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day;

E. Foster care.

(I) If a subscriber or employee enrolls a foster child due to placement in the subscriber or employee's care within thirty-one (31) days of placement, coverage becomes effective on the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day; or

F. Employee.

(I) If an employee enrolls due to a life event, the effective date for the employee is the first day of the next month after enrollment is received, unless enrollment is received on the first day of a month, in which case coverage is effective on that day.

3. An employee and his/her eligible dependent(s) who elect coverage and/or change coverage levels during open enrollment shall have an effective date of January 1 of the following year.

4. Coverage is effective for a dependent child the first of the month coinciding with or after the Qualified Medical Child Support Order is received by the plan or date specified by the court.

(7) Termination.

(A) Unless stated otherwise, termination of coverage shall occur on the last day of the calendar month coinciding with or after the happening of any of the following events, whichever shall occur first:

1. Failure to make any required contribution toward the cost of coverage;

2. Entry into the armed forces of any country;

3. With respect to active employee(s) and his/her dependents, termination of employment in a position covered by the MCHCP, except as expressly specified otherwise in this rule;

4. With respect to dependents, upon divorce or legal separation from the subscriber or when a child reaches age twenty-six (26), or when a dependent is no longer eligible for coverage. A subscriber must terminate coverage for his/her spouse and stepchild(ren) at the time his/her divorce is final.

A. The public entity shall notify MCHCP when any of subscriber's dependents cease to be a dependent as defined in this chapter.

B. When a subscriber drops dependent coverage after a divorce, s/he must submit a completed form, a copy of the divorce decree, and current addresses of all affected dependents. Coverage ends on the last day of the month in which the divorce decree and completed form are received by MCHCP or MCHCP otherwise receives credible evidence of a final divorce that results in loss of member eligibility under the plan;

5. Death of dependent. The dependent's coverage ends on the date of death.

A. The public entity shall notify MCHCP of a dependent's death;

6. A member's act, practice, or omission that constitutes fraud or the member makes an intentional misrepresentation of material fact; or

7. A member's threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP.

(8) Voluntary Cancellation of Coverage.

(C) A subscriber cannot cancel medical coverage on his/her spouse or children during divorce or legal separation proceedings unless s/he submits a notarized letter from his/her spouse stating s/he is agreeable to termination of coverage pending divorce. If premiums are collected pre-tax through a cafeteria plan, medical coverage can only be cancelled at the time of divorce.

(10) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(C) Required Notifications.

1. To be eligible for COBRA, the subscriber or applicable member must notify MCHCP of a divorce, legal separation, a child turning age twenty-six (26), or Medicare entitlement within sixty (60) days of the event date.

2. The human resource/payroll office of the subscriber must notify MCHCP of an employee's death, termination, or reduction of hours of employment.

3. If a COBRA participant is disabled within the first sixty (60) days of COBRA coverage and the disability continues for the rest of the initial eighteen- (18-) month period of continuing coverage, the member must notify MCHCP that s/he wants to continue coverage within sixty (60) days, starting from the latest of: 1) the date on which the SSA issues the disability determination; 2) the date on which the qualifying event occurs; or 3) the date on which the member receives the COBRA general notice. The member must also notify MCHCP within thirty-one (31) days of any final determination that the individual is no longer disabled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.030 Public Entity Membership Agreement and Participation Period **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1833–1834). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.045 Plan Utilization Review Policy **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1834–1835). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1835–1836). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1836). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.055 High Deductible Health Plan Benefit Provisions and Covered Charges **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1836–1837). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1837–1838). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.057 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1838–1845). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT #1: MCHCP staff commented that, under subsection (4)(F), clarification is needed for the benefit for treatment received by a non-network provider in the network hospital or facility.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made with the addition of subparagraph (4)(F)25.H., that if a member received treatment in a network hospital or facility by a non-network provider, services are paid at the network benefit.

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges

(4) Covered Charges Applicable to the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP.

(F) Plan benefits for the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP are as follows:

1. Allergy testing and immunotherapy. Allergy testing and allergy immunotherapy is covered for members with clinically-significant allergic symptoms. No coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning;

2. Ambulance service. Ambulance transport services involve the use of specially-designed and equipped vehicles to transport ill or injured individuals. Ambulance transportation by ground to the nearest appropriate facility is covered when other means of transportation would be contraindicated. This can include emergent and non-emergent, yet medically necessary situations. Ambulance transportation by air to the nearest appropriate facility is covered only if the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Use of air ambulance or medical helicopter service from any country returning to the U.S. is excluded;

3. Applied behavior analysis for autism. For children younger than age nineteen (19), the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior are covered with a forty-one thousand two hundred sixty-three dollar ($41,263) annual limit. The annual limit may be exceeded, upon prior authorization by the medical plan, if services beyond the annual limit continue to be medically necessary;

4. Bariatric surgery. When specific criteria for bariatric surgery have been met, any of the following open or laparoscopic bariatric surgery procedures are covered when performed at a Centers of Excellence Facility for Bariatric Surgery as determined by the Centers for Medicare and Medicaid Services:

A. Roux-en-Y gastric bypass;

B. Sleeve gastrectomy;

C. Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

D. Adjustable silicone gastric banding. Adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure are covered;

E. Surgical reversal of bariatric surgery is covered when complications of the original surgery (such as stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink or cause vomiting of prescribed meals; or

F. Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss is covered when specific criteria is met. Inadequate weight loss due to individual noncompliance with post-operative nutrition and exercise recommendations is not a medically necessary indication for revision or conversion surgery and is not covered;

5. Birth control devices and injections. Birth control is any method used to prevent pregnancy. Food and Drug Administration-(FDA-) approved birth control devices and injections are covered when administered in a physician's office;

6. Blood storage. Storage of whole blood, blood plasma, and blood products is only covered in conjunction with medical treatment that requires immediate blood transfusion support;

7. Cancer trials. Coverage for routine patient care costs incurred as the result of a Phase II, III, or IV clinical trial that is approved by an appropriate entity and is undertaken for the purposes of the prevention, early detection, or treatment of cancer. Coverage includes routine patient care costs incurred for drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's condition. Coverage includes reasonable services needed to administer the drug or use the device under evaluation in the clinical trial;

8. Cardiac rehabilitation. Coverage for an electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) when it is individually prescribed by a physician and a formal exercise stress test is completed following the event and prior to the initiation of the program. Up to thirty-six (36) visits are covered within a twelve- (12-) week period per incident without prior authorization. Any visits after the first thirty-six (36) within a twelve- (12-) week period per incident may be covered, upon prior authorization by the medical plan, if services continue to be medically necessary;

9. Chelation therapy. Chelation therapy agents covered for FDA-approved indication(s) and associated condition(s). Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit are explicitly excluded under MCHCP's benefit plan. Therefore, treatment of metal toxicity that occurs as a result of occupational exposure is not covered;

10. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered. Up to twenty-six (26) visits covered annually. Any visits after the first twenty-six (26) may be covered, upon prior authorization by the medical plan, if services continue to be medically necessary;

11. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation is covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device.

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

12. Dental care/accidental injury. Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors, or cysts. Oral surgery includes but is not limited to reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization. General anesthesia is covered when dental care is provided in a participating or non-participating hospital or surgical center;

13. Durable medical equipment (DME)/medically-necessary disposable supplies. DME is covered when the equipment is ordered by a physician to treat an injury or illness. DME includes, but is not limited to, insulin pumps, oxygen, augmentative communication devices, and manual and powered mobility devices. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, colostomy and ureterostomy bags and prescription compression stockings, are covered. Prescription compression stockings are limited to two (2) pairs or four (4) individual stockings per plan year. Non-reusable disposable supplies, including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure

leotards, surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered. Repair and replacement of DME is covered when—

A. Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

B. Routine wear and tear of the equipment renders it nonfunctional and the member still requires the equipment; or

C. The physician provides documentation that the condition of the member changes or if growth-related;

14. Emergency room services. An emergency medical condition is defined as the manifestation of acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If a member is admitted to hospital, s/he may be required to transfer to network facility for maximum benefit;

15. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

16. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when associated with systemic conditions that are significant enough to result in severe circulatory insufficiency and/or areas of desensitization in the lower extremities and service is provided by a qualified health provider. Foot care is considered routine in nature and not covered in the absence of systemic disease that has resulted in severe circulatory insufficiency and/or areas of desensitization in the lower extremities;

17. Genetic counseling. The National Society of Genetic Counselors defines genetic counseling as: "The process of helping people understand and adapt to the medical, psychological, and familial implications of genetic contributions to disease." Pre-test and post-test genetic counseling with a physician or a licensed or certified genetic counselor covered for an individual recommended for covered heritable genetic testing;

18. Genetic testing. No coverage for testing based on family history alone. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

A. The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

B. The result of the test will directly impact the treatment being delivered to the member;

C. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

D. After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

19. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

20. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars ($200), and the lifetime maximum is three thousand two hundred dollars ($3,200);

21. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars ($1,000).

B. Programmable: two thousand dollars ($2,000).

C. Digital: two thousand five hundred dollars ($2,500).

D. Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars ($3,500);

22. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by physician;

23. Home health care. Skilled home health care is covered for members who are homebound because of illness or injury (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care); services must be performed by a registered nurse or licensed practical (vocational) nurse, licensed therapist, or a registered dietitian;

24. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week;

25. Hospital (includes inpatient, outpatient, and surgical centers). The following benefits are covered:

A. Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

B. Intensive care unit room and board;

C. Surgery, therapies, and ancillary services—

(I) Cornea transplant-travel and lodging are not covered for cornea transplant;

(II) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(III) Sterilization for the purpose of birth control is covered;

(IV) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(V) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19); and

(VI) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

D. Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(I) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(II) The member's mental health disorder must be treatable in an inpatient facility;

(III) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association *Diagnostic and Statistical Manual* (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region; and

(IV) The attending physician must be a psychiatrist. If the admitting physician is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board eligible or board certified. If outside of the United States, inpatient services must be provided by an

individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending physician must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

E. Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment;

F. Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country;

G. Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(I) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(II) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(III) A state-licensed psychologist;

(IV) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(V) Licensed professional counselor; and

H. Treatment in a network hospital or facility by a non-network provider. Treatment received in a network hospital or facility by a non-network provider is covered at the network benefit.

26. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. See birth control devices and injections for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition or alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemotherapy;

(XX) Intestinal bypass or anastamosis status; and

(XXI) Acquired absence of stomach;

27. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition;

28. Maternity coverage. Prenatal and postnatal care is covered. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility;

29. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program. Counseling must be ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian) for up to three (3) sessions annually with a registered dietitian without prior authorization. Any sessions after the three (3) may be covered upon prior authorization by the medical plan, if services continue to be medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program. Conditions for which nutritional evaluation and counseling are not covered include, but are not limited to, the following:

A. Attention-deficit/hyperactivity disorder (ADHD);

B. Chronic fatigue syndrome (CFS);

C. Idiopathic environmental intolerance (IEI); or

D. Asthma;

30. Nutritional therapy. Nutritional therapy is covered when it is—

A. The sole source of nutrition or a significant percentage of the daily caloric intake;

B. Used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

C. Prescribed by a physician;

D. Necessary to sustain life or health; and

E. Requires ongoing evaluation and management by a licensed healthcare provider;

31. Office visit. Member encounter with a health care or mental health care/chemical dependency provider in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan provided;

32. Orthognathic (jaw includes temporomandibular joint and prognathism) surgery is covered for the following specific conditions and when the conditions meet coverage criteria:

A. Acute traumatic injury and post-surgical sequela;

B. Cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequela;

C. Obstructive sleep apnea;

D. Cleft lip/palate (for cleft lip/palate related jaw surgery); and

E. Congenital anomalies. Examples of congenital anomalies include: midface hypoplasia, Pierre Robin Syndrome, Hemifacial Microsomia, and Treacher Collins Syndrome;

33. Orthotics. Therapeutic shoes, inserts, and/or modifications to therapeutic shoes; thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis; helmets—covered when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living; and cranial orthosis for plagiocephaly, cervical orthosis, hip orthosis, knee orthosis, and ankle-foot/knee-ankle-foot orthoses (AFO) are covered;

34. Physical, speech, and occupational therapy and rehabilitation services (outpatient). Up to sixty (60) combined visits allowed per incident. Any visits after the first sixty (60) may be covered upon

prior authorization by the medical plan, if services continue to be medically necessary;

35. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Annual physical exams (well man, woman, and child) and routine lab and X-ray services ordered as part of the annual exam. One (1) exam per calendar year is covered. Additional visits as needed to obtain all necessary preventive services are covered for women depending on a woman's health status, health needs, and other risk factors. For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

F. Cancer screenings—

(I) Mammograms—one (1) exam per year, no age limit;

(II) Pap smears—one (1) per year, no age limit;

(III) Prostate—one (1) per year, no age limit; and

(IV) Colorectal screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Flu vaccination (influenza)—The seasonal flu vaccine is covered under the preventive care benefit. When shot is obtained out of network, member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive up to twenty-five dollars ($25). Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.

(I) Standard or preservative-free injectable influenza vaccine is a covered preventive service for members when influenza immunization is recommended by the member's doctor.

(II) Intradermal influenza vaccine is a covered preventive service for members eighteen (18) to sixty-four (64) years of age when influenza immunization is recommended by the member's doctor.

(III) Intranasally administered influenza vaccine is a covered alternative to injectable influenza vaccine for immunocompetent healthy persons two (2) to forty-nine (49) years of age when influenza immunization is recommended by the member's doctor;

36. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition, or if growth-related;

37. Pulmonary rehabilitation. Up to thirty-six (36) visits within a twelve- (12-) week period per incident. Any visits after the first thirty-six (36) within a twelve- (12-) week period per incident may be covered, upon prior authorization by the medical plan, if services continue to be medically necessary. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) and/or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

38. Skilled nursing facility. Benefits are limited to one hundred twenty (120) days per calendar year;

39. Stimulators (for bone growth). Implantable bone growth stimulators covered as an outpatient surgery, nonimplantable bone growth stimulator covered under durable medical equipment.

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)). Medically-necessary DME to accelerate healing of fresh fractures, fusions, or delayed unions.

B. Electrical stimulation. Direct current electrical bone-growth stimulator medically necessary for delayed unions of fractures or failed arthrodesis, non-unions, failed fusions, and congenital pseudarthrosis and members who are at high risk for spinal fusion failure;

40. Transplants. When neither experimental nor investigational and medically necessary: stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered under the transplant benefits. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements. Travel, if approved, is limited to ten thousand dollars ($10,000) maximum per transplant.

A. Network. Includes travel and lodging allowance for recipient and his/her immediate family travel companion (younger than nineteen (19), both parents) if transplant facility is more than one hundred (100) miles from residence.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Transplant benefits at a non-network facility. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals not covered. Non-network facility charges and payments for transplants are limited to the following maximum only:

(I) Stem cell transplant—

(a) Allogeneic related—one hundred fifty-three thousand dollars ($153,000);

(b) Allogeneic unrelated—one hundred seventy-nine thousand dollars ($179,000); and

(c) Autologous stem cell transplant—one hundred five thousand dollars ($105,000);

(II) Heart—one hundred eighty-five thousand dollars ($185,000);

(III) Heart and lung—two hundred sixty-one thousand three hundred sixty-one dollars ($261,361);

(IV) Lung—one hundred forty-two thousand eight hundred seventeen dollars ($142,817);

(V) Kidney—eighty thousand dollars ($80,000);

(VI) Kidney and pancreas—one hundred thirty thousand dollars ($130,000);

(VII) Liver—one hundred seventy-five thousand nine hundred dollars ($175,900);

(VIII) Pancreas—ninety-five thousand dollars ($95,000); and

(IX) Small bowel—two hundred seventy-five thousand dollars ($275,000);

41. Urgent care. Services provided to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician's office but not severe enough to require treatment in a hospital emergency department; and

42. Vision. One (1) routine exam (including refractions) per covered person per calendar year.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP Limitations **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1846–1847). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, and section 103.089, RSMo Supp. 2012, the director amends a rule as follows:

22 CSR 10-3.070 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1847). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT #1: MCHCP staff commented that under section (4), clarification is needed of Medicare's actual paid amount, not the Medicaid paid amount.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (4)(A)2., that the Medicare's actual paid amount is combined with the provider's Medicare contractual write off to determine what MCHCP considers the Medicare paid amount and not the Medicaid paid amount.

22 CSR 10-3.070 Coordination of Benefits

(4) Effect on the Benefits of MCHCP. This section applies, which in accordance with section (3), Order of Benefit Determination Rules, MCHCP is a secondary plan as to one (1) or more other plans.

(A) In the event that MCHCP is a secondary plan as to one (1) or more other plans, the benefits of MCHCP's PPO plans and High Deductible Plan may be reduced under this section so as not to duplicate the benefits of the other plan. The other plan's payment is subtracted from what MCHCP or its claims administrator would have paid in absence of this COB provision using the following criteria. If there is any balance, MCHCP or its claims administrator will pay the difference not to exceed what it would have paid in absence of this COB provision.

1. In the case where Medicare is primary for physician and outpatient facility claims, Medicare's allowed amount is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision.

2. In the case where Medicare is primary for inpatient facility claims, the amount the facility billed is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision. Medicare's actual paid amount is combined with the provider's Medicare contractual write off to determine what MCHCP considers the Medicare paid amount. Effective April 1, 2013, Medicare's allowed amount will be used as MCHCP's allowed amount for inpatient facility claims to determine what MCHCP would have paid in absence of this COB provision and the Medicare paid amount will no longer be combined with the provider's Medicare contractual write off.

3. In the case where another plan is primary, the lower allowed amount of either the primary plan or MCHCP is used as MCHCP's allowed amount to determine what MCHCP would have paid in absence of this COB provision.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.075 Review and Appeals Procedure **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1847–1850). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.080 Miscellaneous Provisions **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1850). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.090 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1850–1855). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT #1: MCHCP staff commented that, under section (3), clarification is needed of which members may receive the reduced prescription drug copayments.
RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subsection (3)(B) that a member is considered actively participating in the Disease Management Program when s/he is enrolled in a Disease Management Program through the medical plan vendor along with one (1) of the criteria for participation.

22 CSR 10-3.090 Pharmacy Benefit Summary

(3) Disease Management Program Reduced Non-Formulary Prescription Copayments—

(A) Members who are actively participating in the Disease Management Program and enrolled in the PPO 600 Plan, PPO 1000 Plan, or PPO 2000 Plan are eligible for a reduced non-formulary prescription copayment as follows:

1. Fifty-five dollars ($55) for up to a thirty- (30-) day supply for a drug not on the formulary;

2. One hundred ten dollars ($110) for up to a sixty- (60-) day supply for a drug not on the formulary; and

3. One hundred thirty-seven dollars and fifty cents ($137.50) for up to a ninety- (90-) day supply for a drug not on the formulary; and

(B) A member is considered actively participating in the Disease Management Program when s/he is enrolled in a Disease Management Program through the medical plan vendor and one (1) of the following—

1. Is working one-on-one with a nurse; or

2. Has met his/her initial goals for condition control and receives up to two (2) calls per year from a nurse until the condition is managed independently; or

3. The medical plan vendor has determined the member does not require one-on-one work with a nurse.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, and section 103.080.3., RSMo Supp. 2012, the director adopts a rule as follows:

22 CSR 10-3.130 Additional Plan Options **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 3, 2012 (37 MoReg 1856–1857). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

This section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs, and other items required to be published in the *Missouri Register* by law.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

NOTIFICATION OF REVIEW: APPLICATION REVIEW SCHEDULE

The Missouri Health Facilities Review Committee has initiated review of the applications listed below. A decision is tentatively scheduled for April 23, 2013. These applications are available for public inspection at the address shown below:

Date Filed

Project Number: Project Name
City (County)
Cost, Description

3/11/13

#4888 NT: Sikeston Convalescent Center
Sikeston (Scott County)
$1,839,629, Renovate/Modernize 120-bed SNF

#4902 HT: North Kansas City Hospital
North Kansas City (Clay County)
$4,229,939, Replace Linear Accelerator

#4903 HT: North Kansas City Hospital
North Kansas City (Clay County)
$1,663,815, Replace MRI Unit

Any person wishing to request a public hearing for the purpose of commenting on these applications must submit a written request to this effect, which must be received by April 11, 2013. All written requests and comments should be sent to—

Chairman
Missouri Health Facilities Review Committee
c/o Certificate of Need Program
3418 Knipp Drive, Suite F
PO Box 570
Jefferson City, MO 65102

For additional information contact
Karla Houchins, (573) 751-6403.

ADDITION TO STATUTORY LIST OF CONTRACTORS BARRED FROM PUBLIC WORKS PROJECTS

The following is an addition to the list of contractor(s) who have been prosecuted and convicted of violating the Missouri Prevailing Wage Law, and whose Notice of Conviction has been filed with the Secretary of State pursuant to Section 290.330, RSMo. Under this statute, no public body is permitted to award a contract, directly or indirectly, for public works (1) to David E. Mollohan, (2) to any other contractor or subcontractor that is owned, operated or controlled by Mr. David E Mollohan including M & D Excavating or (3) to any other simulation of Mr. David E Mollohan or of M & D Excavating for a period of one year, or until January 10, 2014.

Name of Contractor	Name of Officers	Address	Date of Conviction	Debarment Period
David E. Mollohan d/b/a M & D Excavating Case No. 11WR-CR00453 Wright County Cir. Ct.		1448 Kaylor Road Mountain Grove, MO 65711	1/10/2013	1/10/2013-1/10/2014

Dated this 28th day of January, 2013.

Robert A. Bedell, Acting Division Director

The Secretary of State is required by sections 347.141 and 359.481, RSMo 2000, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript by email to dissolutions@sos.mo.gov.

NOTICE OF WINDING UP FOR LIMITED LIABILITY COMPANY

1. The name of the limited liability company is Charlie's Good Times LLC.

2. The Articles of Organization for Charlie's Good Times LLC were filed with the Missouri Secretary of State on January 10, 2007.

3. On February 14, 2013, Charlie's Good Times LLC filed a Notice of Winding Up for Limited Liability Company with the Secretary of State of Missouri.

4. Persons with claims against Charlie's Good Times LLC should present them in accordance with the following procedure:

   (a) In order to file a claim with Charlie's Good Times LLC, you must furnish the following:

   (i) Amount of the claim
   (ii) Basis for the claim
   (iii)Documentation for the claim

   (b) The claim must be mailed to:

   Ms. Beth S. Miller
   2998 Montecielo Drive
   Santa Ynez, CA 93460

5. A claim against Charlie's Good Times LLC will be barred unless a proceeding to enforce the claim is commenced within three (3) years after publication of this notice.

Be it hereby known to all that R&R Global Development, LLC – Charter # LC0932593 whose articles of organization were first filed on 11/25/2008 with the Missouri Secretary of State's office is hereby dissolving operations effective 12/31/2012 or any date accepted by the Missouri Secretary of State's office. A notice of Winding Up for Limited Liability Company (LLC-13) and Articles of Termination for Limited liability Company (LLC-5) have been files with the Missouri SOS office. This move was approved by unanimous consent of all equity partners in writing in January 1, 2013. Any all claims against R&R Global Development, LLC must be submitted in writing with documentation/proof of claim to:

CLAIMS – R&R Global Development, LLC C/O Team RS Financial
11116 South Towne Square #102
Saint Louis, MO 63123

**NOTICE OF DISSOLUTION
TO ALL CREDITORS OF AND
CLAIMANTS AGAINST
ELITE GROWTH STRATEGIES LLC**

On February 4, 2013, Elite Growth Strategies LLC, a Missouri limited liability company (the "Company"), filed its Notice of Winding Up for a Limited Liability Company with the Secretary of State of Missouri. The Company requests that any and all claims against the Company be presented by letter to the Company in care of Riezman Berger, P.C., c/o Christine P. Mace, 7700 Bonhomme Avenue, 7th Floor, St. Louis, Missouri 63105. Each claim against the Company must include the following information: the name, the address and telephone number of the claimant; the amount of the claim; the date on which the claim arose; a brief description of the nature of or the basis for the claim; and any documentation related to the claim. All claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

**NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY
TO ALL CREDITORS OF AND CLAIMANTS AGAINST
PLAINVIEW PARK APARTMENTS, LLC**

On February 25, 2013, Plainview Park Apartments, LLC, a Missouri limited liability company ("Company"), filed its Notice of Winding Up with the Missouri Secretary of State, effective on the filing date.

All persons and organizations must submit to Company, c/o Frank C. Carnahan, Carnahan, Evans, Cantwell & Brown, P.C., 2805 S. Ingram Mill, Springfield, Missouri 65804, a written summary of any claims against Company, including: 1) claimant's name, address and telephone number; 2) amount of claim; 3) date(s) claim accrued (or will accrue); 4) brief description of the nature of the debt or the basis for the claim; and 5) if the claim is secured, and if so, the collateral used as security.

Because of the dissolution, any claims against Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the last of filing or publication of this Notice.

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*, citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—37 (2012) and 38 (2013). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	OFFICE OF ADMINISTRATION				
1 CSR 10	State Officials' Salary Compensation Schedule				37 MoReg 1859
1 CSR 10-15.010	Commissioner of Administration	38 MoReg 5	38 MoReg 7		
	DEPARTMENT OF AGRICULTURE				
2 CSR 30-2.020	Animal Health	37 MoReg 1699	37 MoReg 1762	38 MoReg 472	
2 CSR 30-10.010	Animal Health	38 MoReg 5	38 MoReg 82		
2 CSR 70-11.070	Plant Industries	37 MoReg 1637	37 MoReg 1640	38 MoReg 430	
2 CSR 90-10	Weights and Measures				37 MoReg 1197
	DEPARTMENT OF CONSERVATION				
3 CSR 10-7.431	Conservation Commission		38 MoReg 248		
3 CSR 10-7.455	Conservation Commission		38 MoReg 248		38 MoReg 212
	DEPARTMENT OF ECONOMIC DEVELOPMENT				
4 CSR 195-6.010	Division of Workforce Development		38 MoReg 171		
4 CSR 195-6.020	Division of Workforce Development		38 MoReg 171		
4 CSR 195-6.030	Division of Workforce Development		38 MoReg 172		
4 CSR 195-6.040	Division of Workforce Development		38 MoReg 173		
4 CSR 195-6.050	Division of Workforce Development		38 MoReg 173		
4 CSR 240-40.020	Public Service Commission		38 MoReg 82		
4 CSR 240-40.030	Public Service Commission		38 MoReg 86		
4 CSR 240-40.080	Public Service Commission		38 MoReg 99		
	DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION				
5 CSR 20-100.255	Division of Learning Services		37 MoReg 1571	This IssueF	
5 CSR 20-100.260	Division of Learning Services		38 MoReg 99		
5 CSR 20-200.280	Division of Learning Services		37 MoReg 1766	This Issue	
5 CSR 20-300.110	Division of Learning Services		N.A.	This Issue	
5 CSR 20-300.120	Division of Learning Services		N.A.	This Issue	
5 CSR 20-400.125	Division of Learning Services		This Issue		
5 CSR 20-400.270	Division of Learning Services		38 MoReg 105		
5 CSR 20-400.280	Division of Learning Services		37 MoReg 1643	This Issue	
5 CSR 20-400.310	Division of Learning Services		37 MoReg 1450	38 MoReg 370	
5 CSR 20-400.340	Division of Learning Services		37 MoReg 1453R	38 MoReg 370R	
5 CSR 20-400.350	Division of Learning Services		37 MoReg 1453R	38 MoReg 370R	
5 CSR 20-400.420	Division of Learning Services		37 MoReg 1453R	38 MoReg 370R	
5 CSR 20-400.440	Division of Learning Services		37 MoReg 1453	38 MoReg 371	
5 CSR 20-600.110	Division of Learning Services		This Issue		
5 CSR 20-600.130	Division of Learning Services		37 MoReg 1457	38 MoReg 373	
	DEPARTMENT OF HIGHER EDUCATION				
6 CSR 10-2.190	Commissioner of Higher Education		38 MoReg 174		
	DEPARTMENT OF TRANSPORTATION				
7 CSR 10-7.020	Missouri Highways and Transportation Commission		38 MoReg 427		
7 CSR 10-7.030	Missouri Highways and Transportation Commission		38 MoReg 427		
7 CSR 10-25.010	Missouri Highways and Transportation Commission				38 MoReg 431
	DEPARTMENT OF NATURAL RESOURCES				
10 CSR 10-1.010	Air Conservation Commission		37 MoReg 1646		
10 CSR 10-2.330	Air Conservation Commission		37 MoReg 1769		
10 CSR 10-6.191	Air Conservation Commission		37 MoReg 1460		
10 CSR 10-6.368	Air Conservation Commission		37 MoReg 1460R		
10 CSR 23-1.075	Division of Geology and Land Survey		38 MoReg 283		
10 CSR 40-3.040	Land Reclamation Commission		38 MoReg 177		
10 CSR 40-3.060	Land Reclamation Commission		38 MoReg 178		
10 CSR 40-3.170	Land Reclamation Commission		38 MoReg 178		
10 CSR 40-3.180	Land Reclamation Commission		38 MoReg 178		
10 CSR 40-3.200	Land Reclamation Commission		38 MoReg 179		
10 CSR 40-3.210	Land Reclamation Commission		38 MoReg 181		
10 CSR 40-3.220	Land Reclamation Commission		38 MoReg 181		
10 CSR 40-3.230	Land Reclamation Commission		38 MoReg 182		
10 CSR 40-3.240	Land Reclamation Commission		38 MoReg 182		
10 CSR 40-3.260	Land Reclamation Commission		38 MoReg 182		
10 CSR 40-3.300	Land Reclamation Commission		38 MoReg 183		
10 CSR 40-6.020	Land Reclamation Commission		38 MoReg 183		
10 CSR 40-6.030	Land Reclamation Commission		38 MoReg 184		
10 CSR 40-6.040	Land Reclamation Commission		38 MoReg 184		
10 CSR 40-6.050	Land Reclamation Commission		38 MoReg 185		
10 CSR 40-6.060	Land Reclamation Commission		38 MoReg 185		
10 CSR 40-6.070	Land Reclamation Commission		38 MoReg 186		
10 CSR 40-6.100	Land Reclamation Commission		38 MoReg 187		
10 CSR 40-6.110	Land Reclamation Commission		38 MoReg 187		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
10 CSR 40-6.120	Land Reclamation Commission		38 MoReg 188		
10 CSR 40-7.050	Land Reclamation Commission		38 MoReg 189		
10 CSR 40-8.010	Land Reclamation Commission		38 MoReg 190		
10 CSR 40-8.020	Land Reclamation Commission		38 MoReg 195		
10 CSR 40-8.070	Land Reclamation Commission		38 MoReg 195		
10 CSR 100-2.010	Petroleum Storage Tank Insurance Fund Board of Trustees		37 MoReg 1395	38 MoReg 251	
10 CSR 100-4.010	Petroleum Storage Tank Insurance Fund Board of Trustees		37 MoReg 1395	38 MoReg 251	
10 CSR 100-4.020	Petroleum Storage Tank Insurance Fund Board of Trustees		37 MoReg 1397	38 MoReg 251	
10 CSR 140-2	Division of Energy				38 MoReg 432
	DEPARTMENT OF PUBLIC SAFETY				
11 CSR 30-14.010	Office of the Director	38 MoReg 243	38 MoReg 249		
11 CSR 45-4.050	Missouri Gaming Commission		37 MoReg 1461R	38 MoReg 375R	
11 CSR 45-4.055	Missouri Gaming Commission		37 MoReg 1461	38 MoReg 375	
11 CSR 45-4.190	Missouri Gaming Commission		37 MoReg 1462	38 MoReg 377	
11 CSR 45-4.205	Missouri Gaming Commission		37 MoReg 1462	38 MoReg 377	
11 CSR 45-4.240	Missouri Gaming Commission		37 MoReg 1462	38 MoReg 377	
11 CSR 45-4.250	Missouri Gaming Commission		37 MoReg 1463	38 MoReg 377	
11 CSR 45-4.260	Missouri Gaming Commission		37 MoReg 1463 38 MoReg 428	38 MoReg 377	
11 CSR 45-4.380	Missouri Gaming Commission		37 MoReg 1463	38 MoReg 378	
11 CSR 45-4.390	Missouri Gaming Commission		37 MoReg 1464	38 MoReg 378	
11 CSR 45-5.184	Missouri Gaming Commission		37 MoReg 1464	38 MoReg 378	
11 CSR 45-5.193	Missouri Gaming Commission		37 MoReg 1583		
11 CSR 45-8.130	Missouri Gaming Commission		37 MoReg 1466	38 MoReg 379	
11 CSR 45-9.105	Missouri Gaming Commission		37 MoReg 1583		
11 CSR 45-9.106	Missouri Gaming Commission		37 MoReg 1770		
11 CSR 45-9.118	Missouri Gaming Commission		37 MoReg 1587		
11 CSR 45-9.120	Missouri Gaming Commission		37 MoReg 1770		
11 CSR 50-3.100	Missouri State Highway Patrol	37 MoReg 1439	37 MoReg 1472		
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19 CSR 30-40.790	Division of Regulation and Licensure		37 MoReg 2285		
19 CSR 60-50	Missouri Health Facilties Review Committee				38 MoReg 253 38 MoReg 479 38 MoReg 479 This Issue

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20 CSR	Sovereign Immunity Limits				37 MoReg 62 38 MoReg 147
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20 CSR 2200-2.040	State Board of Nursing		38 MoReg 297		
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20 CSR 2200-2.100	State Board of Nursing		38 MoReg 301		
20 CSR 2200-2.110	State Board of Nursing		38 MoReg 303		
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20 CSR 2200-2.130	State Board of Nursing		38 MoReg 303		
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20 CSR 2245-2.010	Real Estate Appraisers		37 MoReg 2299		
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20 CSR 2270-4.042	Missouri Veterinary Medical Board		38 MoReg 368		

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	MISSOURI CONSOLIDATED HEALTH CARE PLAN				
22 CSR 10-2.010	Health Care Plan	37 MoReg 1701	37 MoReg 1774	This Issue	
22 CSR 10-2.020	Health Care Plan	37 MoReg 1705R 37 MoReg 1705 This IssueRT This IssueT	37 MoReg 1778R 37 MoReg 1778	This IssueR This Issue	
22 CSR 10-2.030	Health Care Plan		37 MoReg 1790	This Issue	
22 CSR 10-2.045	Health Care Plan	37 MoReg 1715	37 MoReg 1794	This Issue	
22 CSR 10-2.051	Health Care Plan	37 MoReg 1716	37 MoReg 1795	This Issue	
22 CSR 10-2.052	Health Care Plan	37 MoReg 1717	37 MoReg 1795	This Issue	
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22 CSR 10-3.060	Health Care Plan	37 MoReg 1754	37 MoReg 1846	This Issue	
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22 CSR 10-3.090	Health Care Plan	37 MoReg 1758 This IssueT	37 MoReg 1850	This Issue	
22 CSR 10-3.130	Health Care Plan	37 MoReg 1761	37 MoReg 1856	This Issue	

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Office of Administration				
Commissioner of Administration				
1 CSR 10-15.010	Cafeteria Plan	38 MoReg 5	Jan. 1, 2013	June 29, 2013
Department of Agriculture				
Animal Health				
2 CSR 30-2.020	Movement of Livestock, Poultry, and Exotic Animals Within Missouri	37 MoReg 1699	Nov. 8, 2012	May 6, 2013
2 CSR 30-10.010	Inspection of Meat and Poultry	38 MoReg 5	Jan. 1, 2013	June 29, 2013
Plant Industries				
2 CSR 70-11.070	Pine Shoot Beetle Intrastate Quarantine	37 MoReg 1637	Oct. 12, 2012	April 9, 2013
Department of Public Safety				
Office of the Director				
11 CSR 30-14.010	Approval of Accrediting Organizations for Crime Laboratories	38 MoReg 243	Jan. 18, 2013	July 16, 2013
Department of Revenue				
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12 CSR 10-41.010	Annual Adjusted Rate of Interest	37 MoReg 1701	Jan. 1, 2013	June 29, 2013
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15 CSR 50-4.030	Missouri MOST 529 Matching Grant Program	38 MoReg 425	Feb. 2, 2013	July 31, 2013
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22 CSR 10-2.010	Definitions	37 MoReg 1701	Jan. 1, 2013	June 29, 2013
22 CSR 10-2.020	General Membership Provisions	37 MoReg 1702	Jan. 1, 2013 .term.	May 29, 2013
22 CSR 10-2.020	General Membership Provisions	37 MoReg 1702	Jan. 1, 2013 .term.	May 29, 2013
22 CSR 10-2.045	Plan Utilization Review Policy	37 MoReg 1715	Jan. 1, 2013	June 29, 2013
22 CSR 10-2.051	PPO 300 Plan Benefit Provisions and Covered Charges	37 MoReg 1716	Jan. 1, 2013	June 29, 2013
22 CSR 10-2.052	PPO 600 Plan Benefit Provisions and Covered Charges	37 MoReg 1717	Jan. 1, 2013	June 29, 2013
22 CSR 10-2.053	High Deductible Health Plan Benefit Provisions and Covered Charges	37 MoReg 1717	Jan. 1, 2013 .term.	May 29, 2013
22 CSR 10-2.055	Medical Plan Benefit Provisions and Covered Charges	37 MoReg 1719	Jan. 1, 2013 .term.	May 29, 2013
22 CSR 10-2.060	PPO 300 Plan, PPO 600 Plan, and HDHP Limitations	37 MoReg 1724	Jan. 1, 2013	June 29, 2013
22 CSR 10-2.070	Coordination of Benefits	37 MoReg 1726	Jan. 1, 2013 .term.	May 29, 2013
22 CSR 10-2.075	Review and Appeals Procedure	37 MoReg 1727	Jan. 1, 2013	June 29, 2013
22 CSR 10-2.090	Pharmacy Benefit Summary	37 MoReg 1729	Jan. 1, 2013 .term.	May 29, 2013
22 CSR 10-2.091	Wellness Program Coverage, Provisions, and Limitations	37 MoReg 1732	Jan. 1, 2013	June 29, 2013
22 CSR 10-2.130	Additional Plan Options	37 MoReg 1732	Jan. 1, 2013	June 29, 2013
22 CSR 10-3.010	Definitions	37 MoReg 1733	Jan. 1, 2013	June 29, 2013
22 CSR 10-3.020	General Membership Provisions	37 MoReg 1736	Jan. 1, 2013 .term.	May 29, 2013
22 CSR 10-3.020	General Membership Provisions	37 MoReg 1736	Jan. 1, 2013 .term.	May 29, 2013
22 CSR 10-3.045	Plan Utilization Review Policy	37 MoReg 1743	Jan. 1, 2013	June 29, 2013
22 CSR 10-3.053	PPO 1000 Plan Benefit Provisions and Covered Charges	37 MoReg 1744	Jan. 1, 2013	June 29, 2013
22 CSR 10-3.054	PPO 2000 Plan Benefit Provisions and Covered Charges	37 MoReg 1745	Jan. 1, 2013	June 29, 2013
22 CSR 10-3.055	High Deductible Health Plan Benefit Provisions and Covered Charges	37 MoReg 1746	Jan. 1, 2013	June 29, 2013
22 CSR 10-3.056	PPO 600 Plan Benefit Provisions and Covered Charges	37 MoReg 1747	Jan. 1, 2013	June 29, 2013
22 CSR 10-3.057	Medical Plan Benefit Provisions and Covered Charges	37 MoReg 1748	Jan. 1, 2013 .term.	May 29, 2013
22 CSR 10-3.060	PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP Limitations	37 MoReg 1754	Jan. 1, 2013	June 29, 2013
22 CSR 10-3.070	Coordination of Benefits	37 MoReg 1755	Jan. 1, 2013 .term.	May 29, 2013
22 CSR 10-3.075	Review and Appeals Procedure	37 MoReg 1756	Jan. 1, 2013	June 29, 2013
22 CSR 10-3.090	Pharmacy Benefit Summary	37 MoReg 1758	Jan. 1, 2013 .term.	May 29, 2013
22 CSR 10-3.130	Additional Plan Options	37 MoReg 1761	Jan. 1, 2013	June 29, 2013

Executive Orders	Subject Matter	Filed Date	Publication
	2013		
13-05	Declares a state of emergency and directs that the Missouri State Emergency Operations Plan be activated due to severe weather that began on Feb. 20, 2013.	Feb. 21, 2013	This Issue
13-04	Expresses the commitment of the state of Missouri to the establishment of Western Governors University (WGU) as a non-profit institution of higher education located in Missouri that will provide enhanced access for Missourians to enroll in and complete on-line, competency-based higher education programs. Contemporaneously with this Executive Order, the state of Missouri is entering into a Memorandum of Understanding (MOU) with WGU to further memorialize and establish the partnership between the state of Missouri and WGU.	Feb. 15, 2013	38 MoReg 467
13-03	Orders the transfer of the Division of Energy from the Missouri Department of Natural Resources to the Missouri Department of Economic Development.	Feb. 4, 2013	38 MoReg 465
13-02	Orders the transfer of the post-issuance compliance functions for tax credit and job incentive programs from the Missouri Department of Economic Development to the Missouri Department of Revenue.	Feb. 4, 2013	38 MoReg 463
13-01	Orders the transfer of the Center for Emergency Response and Terrorism from the Department of Health and Senior Services to the Department of Public Safety.	Feb. 4, 2013	38 MoReg 461
	2012		
12-12	Reauthorizes the Governor's Committee to End Chronic Homelessness until December 31, 2016.	Dec. 31, 2012	38 MoReg 246
12-11	Advises that state offices located in Cole County will be closed on Monday, January 14, 2013, for the inauguration.	Dec. 20, 2012	38 MoReg 245
12-10	Advises that state offices will be closed on Friday November 23, 2012.	Nov. 2, 2012	37 MoReg 1639
12-09	Extends Executive Order 12-08 in order to extend the deadline for completion of approved projects under the Emergency Cost-Share Program and establishes a Program Audit and Compliance Team to inspect a sample of completed projects. It also extends Executive Order 12-07 until Nov. 15, 2012.	Sept. 10, 2012	37 MoReg 1519
12-08	Authorizes the State Soil and Water Districts Commission to implement an emergency cost-share program to address water challenges to landowners engaged in livestock or crop production due to the current drought. Additionally, it establishes the Agriculture Water Resource Technical Review Team.	July 23, 2012	37 MoReg 1294
12-07	Declares a state of emergency, directs the Missouri State Emergency Operations Plan be activated, and extends Executive Order 12-06 to Oct. 1, 2012, in response to the severe heat, dry conditions, and fire risks affecting the state.	July 23, 2012	37 MoReg 1292
12-06	Activates the Missouri State Emergency Operations Center and directs the State Emergency Management Agency, State Fire Marshall, Adjutant General, and such other agencies to coordinate with local authorities affected by fire danger due to the prolonged period of record heat and low precipitation.	June 29, 2012	37 MoReg 1139
12-05	Extends Executive Orders 11-06, 12-03, 11-07, 11-11, 11-14, and 12-04 until June 1, 2012.	March 13, 2012	37 MoReg 569
12-04	Activates the state militia in response to severe weather that began on February 28, 2012.	Feb. 29, 2012	37 MoReg 503
12-03	Declares a state of emergency and directs that the Missouri State Emergency Operations Plan be activated due to the severe weather that began on February 28, 2012.	Feb. 29, 2012	37 MoReg 501
12-02	Orders the transfer of all authority, powers, and duties of all remaining audit and compliance responsibilities relating to Medicaid Title XIX, SCHIP Title XXI, and Medicaid Waiver programs from the Dept. of Health and Senior Services and the Dept. of Mental Health to the Dept. of Social Services effective Aug. 28, 2012, unless disapproved within sixty days of its submission to the Second Regular Session of the 96th General Assembly.	Jan. 23, 2012	37 MoReg 313
12-01	Designates members of the governor's staff to have supervisory authority over certain departments, divisions, and agencies.	Jan. 23, 2012	37 MoReg 311

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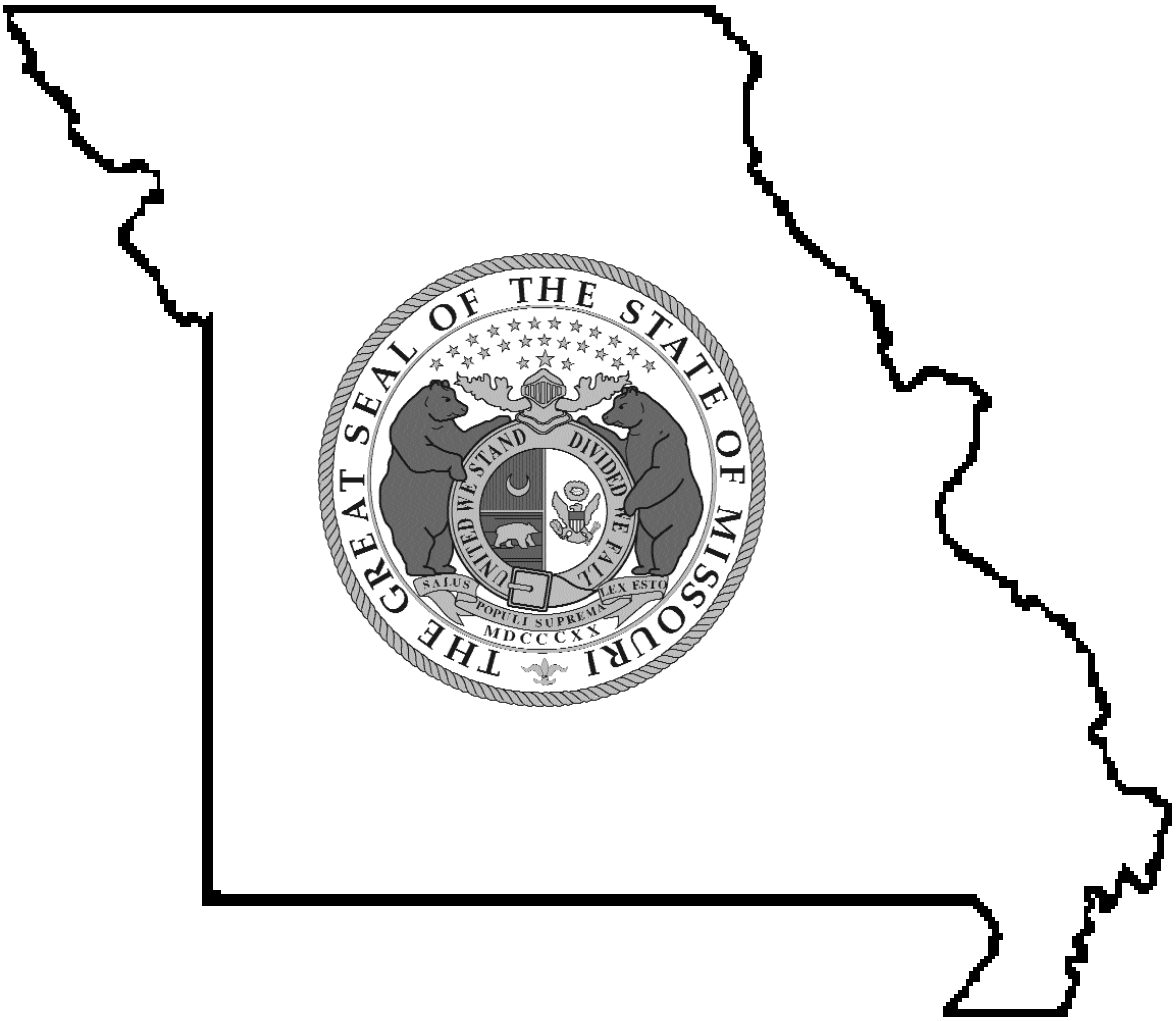
RULEMAKING 1-2-3

DRAFTING AND STYLE MANUAL



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